

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-011346

FILED VS MAR 29 1960 / 46

Registration District No. 3026 Primary Registration District No. 171 Registrar's No. 171

STATE FILE NUMBER

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence | | Length of stay in 1b 46 years | c. CITY OR TOWN Independence Inside Limits Year <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 524 So. Forest | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 524 So. Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | |
|---|-------------------|---|----------------|
| 3. NAME OF DECEASED (Type or print) NORA M. CLAYTON | First Middle Last | 4. DATE OF DEATH March 21, 1960 | Month Day Year |
|---|-------------------|---|----------------|

| | | | | | | |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|------------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-2-1889 | 9. AGE (last birthday) 70 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|------------------------------|

| | | | |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (City and state or country) Pawnee Rock, Kansas | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|---|--|--|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME James E. Kane | 13b. MOTHER'S MAIDEN NAME Mary Hamilton | 14. NAME OF HUSBAND OR WIFE Joseph A. Clayton |
|--|---|---|

| | | | |
|--|---|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> no | 16. SOCIAL SECURITY NO. 490-09-2117 | 17. INFORMANT Joseph A. Clayton, 524 So. Forest, Indep., Mo. | Address |
|--|---|--|---------|

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Military Tuberculosis | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | |

| | |
|---|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|---|

| | | |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|--|---|--|

| | | | |
|---|---|--|--|
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
|---|---|--|--|

| |
|--|
| 21. I attended the deceased from Jan. 59 to Mar 21-60 and last saw her alive on Mar. 1-1960 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) John M. Hunter, M.D. | 22b. ADDRESS 1402 Bryant Bldg, C. Mo | 22c. DATE SIGNED 3-21-60 |
|---|--|------------------------------------|

| | | | |
|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-23-60 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
|--|-----------------------------|---|---|

| | | | |
|---|---------|--|--|
| 24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Independence, Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 3-23-60 | 26. REGISTRAR'S SIGNATURE James K. [Signature] |
|---|---------|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond J. Osborne

Licensed Embalmer No. 4260

P. O. Address Dundee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.