

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014540

FILED VS MAY 5 1960

393

Primary Registration District No. 1002

Registrar's No. 2130

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>CLAY</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>6 YRS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4449 N. WALROND</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4453 N. WALROND</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>B.</b> Last <b>TICKNOR</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>14</b> Year <b>60</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-21-1877</b>		9. AGE (last birthday) <b>82</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Summitville Ind. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13a. FATHER'S NAME <b>E.P. THURSTON</b>			13b. MOTHER'S MAIDEN NAME <b>JOHANNA RUNYON</b>			14. NAME OF HUSBAND OR WIFE <b>OLNEY TICKNOR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>RALPH SMITH 4449 N. WALROND</b>			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) <b>Congestive Heart failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular disease</b>							<b>15 years</b>		
DUE TO (c) <b>Generalized Arteriosclerosis</b>							<b>20-25 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchial Asthma (allergic)</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 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 <b>Apr 1 1960</b> to <b>Apr 14 1960</b> and last saw her/him alive on <b>Apr 13 1960</b> Death occurred at <b>8:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>James E. McCombs, MD</b> (Degree or title)				22b. ADDRESS <b>4030 N Oak, KC 16 MO</b>		22c. DATE SIGNED <b>4/15/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4-16-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Excelsior Springs MO</b>			
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons N.K.C.</b>				ADDRESS <b>4-15-60</b>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <b>newcomers</b>	

DOCUMENT

BY AFFIDAVIT OF JAMES E. MC COMBS, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John V. Amick*

Licensed Embalmer No. 4848

P. O. Address Keokuk, Ia.

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.