

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015264
STATE FILE NUMBER

FILED VS APR 25 1960 49 Primary Registration District No. 1002 Registrar's No. 1865

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY PLATTE							
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 4 DAYS		c. CITY OR TOWN PARKVILLE		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R # 4		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First GERALD Middle D. DOYLE Last				4. DATE OF DEATH Month MARCH Day 31 Year 1960							
5. SEX MALE		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 1/25/1899		9. AGE (last birthday) 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY PHARMACEUTICAL		11. BIRTHPLACE (City and state or country) UPLAND, NEBRASKA		12. CITIZEN OF WHAT COUNTRY U.S.A.		IF UNDER 1 YEAR Months Days			
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME DOYLE UNKNOWN		14. NAME OF HUSBAND OR WIFE MABEL DOYLE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.# 1		16. SOCIAL SECURITY NO. 495/07/8947			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.# 1		16. SOCIAL SECURITY NO. 495/07/8947		17. INFORMANT MRS. MA BEL DOYLE, PARKVILLE, MO, R#4		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma of Lung</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH			
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 type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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 <i>2/15/60</i> to <i>3/31-60</i> and last saw her alive on <i>3/31-60</i> Death occurred at <i>12:30 p.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22. SIGNATURE <i>Clark L. Henry MD</i> (Degree or title)				22b. ADDRESS <i>Playa Vista Blvd, Kansas</i>				22c. DATE SIGNED <i>4/1/60</i>			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE <i>4/2/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>EAST SLOPE CEMETERY</i>		23d. LOCATION (City, town, or county) <i>RIVERSIDE, MO.</i>		23e. (State)			
24. FUNERAL DIRECTOR <i>D.W. NEWCOMERS SONS, N.K.C. 16 MO.</i>				25. DATE RECD. BY LOCAL REG. <i>4-1-60</i>		26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Clark L. Henry

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

Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K. C. 18. W.

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.