

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. MAY 16 1960 149

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2299

60-015377
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas city mo</u>		Length of stay in 1b <u>3 5 yrs</u>		c. CITY OR TOWN <u>Kansas city, mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3033 Spruce</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3033 Spruce</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Phillip</u> Middle <u>Smith</u> Last <u>Hayward</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1960</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-24-1863</u>		9. AGE (last birthday) <u>97</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Webster Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Nesitah Hayward</u>				13b. MOTHER'S MAIDEN NAME <u>Oline Weight</u>				14. NAME OF HUSBAND OR WIFE <u>Mabel Hayward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mabel Hayward 3033 Spruce K.C. Mo</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										<u>2 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Degeneration</u>										<u>1 hr</u>	
DUE TO (c) <u>Nephritis Ch.</u>										<u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not-related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis (Severe)</u>								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 <u>April 17 1960</u> and last saw ^{her} him alive on <u>Apr 17, 1960</u> Death occurred at <u>10:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>John M. Powers M.D.</u>				22b. ADDRESS <u>3304 Linwood Blvd</u>				22c. DATE SIGNED <u>4/23/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-25-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah</u>		23d. LOCATION (City, town, or county) <u>Kansas city mo</u>		(State)			
24. FUNERAL DIRECTOR <u>France-Wornall Funeral Home</u>				25. DATE RECD. BY LOCAL REG. <u>4-25-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>					

DOCUMENT

BY AFFIDAVIT OF John M. Powers, 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
or by James C Anderson, Student Embalmer No. 59
working under my personal supervision.

Student James C Anderson
Signature of Student Embalmer

Signed Russell N. Friedman

Licensed Embalmer No. 42

P. O. Address KC 7

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.