

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015443

FILED VS. MAY 5 1960

149

Primary Registration District No. 1002 Registrar's No.

2160

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>58 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>708 Garfield</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>708 Garfield</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Cowie</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16,</b> Year <b>1960</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>June 19, 1873</b>	9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>27</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Barrhill, Scotland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>James Cowie</b>			13b. MOTHER'S MAIDEN NAME <b>Elizabeth Barrowman</b>		14. NAME OF HUSBAND OR WIFE <b>George P. Kelly</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>None</b>	17. INFORMANT Address <b>Miss Elizabeth Hogsett 300 Armour blvd</b>				
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>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>8 yrs</b>	
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 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 <b>10-15-59</b> to <b>4-16-60</b> and last saw her/him alive on <b>4-16-60</b> Death occurred at <b>10 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Frank Paul Lawrence MD</b>				22b. ADDRESS <b>428 S. White Ave</b>		22c. DATE SIGNED <b>4-16-60</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		DATE <b>April 18, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b>			ADDRESS <b>3235 Gillham Plaza</b>	25. DATE RECD. BY LOCAL REG. <b>4-18-60</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		

DOCUMENT

BY AFFIDAVIT OF  
FRANK PAUL LAWRENCE, 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed William M. Furness

Licensed Embalmer No. 4648  
Haines City

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.