

I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015496

FILED VS. APR 26 1960

2026

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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</u>		Length of stay in 1b <u>15 yrs</u>	c. CITY OR TOWN <u>Kansas City</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>2614 Truman Rd.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>2614 Truman Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Marsh</u> (Last) Middle <u>Doyle</u> Last <u>Doyle</u>			4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1907</u>	9. AGE (last birthday) <u>52</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>Shipping Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>White Engine Co.</u>	11. BIRTHPLACE (City and state or country) <u>Tekomah Nebraska</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John A. Marsh</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Hopper</u>		14. NAME OF HUSBAND OR WIFE <u>Edith Dickover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>			16. SOCIAL SECURITY NO. <u>400-16-2308</u>		17. INFORMANT <u>Edith Dickover</u> Address <u>5233 Cleveland</u>
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>Acute Cardiac Failure</u>					<u>1-2 hrs</u>
DUE TO (b) <u>Acute Coronary Occlusion</u>					<u>2 wks.</u>
DUE TO (c) <u>Coronary Sclerosis &amp; Insufficiency</u>					<u>5-10 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, emphysema, chronic bronchitis.</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 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 <u>3/28/60</u> to <u>4/10/60</u> and last saw <u>him</u> alive on <u>4/9/60</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William P. Adams, D.O.</u> (Degree or title)			22b. ADDRESS <u>3221 Independence, K. C. 24, Mo.</u>		22c. DATE SIGNED <u>4/11/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tekomah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Tekomah Neb.</u>	
24. FUNERAL DIRECTOR <u>Sheil Funeral Home K. C. Missouri</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-11-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

William P. Adams

-01-

**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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address R.E. 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.