

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015500

FILED VS MAY 5 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2164

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 1b <b>2 Weeks</b>		c. CITY OR TOWN <b>Independence</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>St Joseph's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1431 W 28th St Terr</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DORIS</b> Middle <b>JOAN</b> Last <b>MASON</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7/29/1933</b>	9. AGE (last birthday) <b>26</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Key Punch Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Black Syvils &amp; Bryson</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Vernon E Hohensee</b>			13b. MOTHER'S MAIDEN NAME <b>June Mason</b>			14. NAME OF HUSBAND OR WIFE <b>—</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>486-34-8165</b>		17. INFORMANT <b>Kenneth Wheeler 1431 W 28th Terr Indep Mo</b>				
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 <b>24 hours</b>	
IMMEDIATE CAUSE (a) <b>CEREBRAL EDEMA</b>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
DUE TO (b) <b>—</b>								
DUE TO (c) <b>CONGENITAL CEREBRAL ANEURYSM</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 checked="" 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 <b>—</b> Month, Day, Year <b>—</b> a.m. p.m.								
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>4-8-60</b> to <b>4-15-60</b> and last saw her alive on <b>4-15-60</b> Death occurred at <b>2:00 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>[Signature]</b> (Degree or title)				22b. ADDRESS <b>228 Plaza Time Bldg</b>		22c. DATE SIGNED <b>4-18-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>—</b>		23d. LOCATION (City, town, or county) (State) <b>Blue Springs Mo.</b>				
24. FUNERAL DIRECTOR <b>G. Shell Funeral Home Kansas City Mo</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-18-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 J. Patrick Heil

Licensed Embalmer No. 5070

P. O. Address R. C. Mce

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.