

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015651

FILED VS MAY 9 1960

149

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

2263

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>		b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>62 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1316 E. Armorel</u> <u>Colma Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>5711 Holmes</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Harriette</u>		Middle <u>Benton</u>		Last <u>Stanwood</u>		Date of Death <u>4 20 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug retail</u>		11. BIRTHPLACE (City and state or country) <u>Lafayette Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Richard N. Benton</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>James N. Stanwood</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>Carolyn Cocke Fair</u> Address <u>15 C. MO 807 W. 47th</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>Bronchopneumonia - extensive</u>							<u>2 days.</u>
DUE TO (b) <u>Cachexia & inanition</u>							<u>5 Years.</u>
DUE TO (c) <u>Advanced Cerebral Arteriosclerosis</u>							<u>8 Years.</u>
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 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>1954</u> to <u>20 April 1960</u> and last saw ^{her} him alive on <u>19 April 1960</u> Death occurred at <u>2:00</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Philip G. Kaul M.D.</u>				22b. ADDRESS <u>411 Nichols Road</u>			22c. DATE SIGNED <u>22 April 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4-23-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Odessa, MO</u>		(State)
24. FUNERAL DIRECTOR <u>C. N. Blackman & Son</u>		ADDRESS <u>K.C. MO</u>		25. DATE RECD. BY LOCAL REG. <u>4-22-60</u>		26. REGISTRAR'S SIGNATURE <u>Walter Minshall</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Philip G. Kaul

Plaza Terrace Bldg

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 W.C. Purvis

Licensed Embalmer No. 4879

P. O. Address H.C. No

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.