

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015789

FILED VS. APR 19 1960

146

Primary Registration District No. 4237

Registrar's No. 210

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>IOWA</b> b. COUNTY <b>ADAMS</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RAYTOWN ILL</b>		Length of stay in 1b <b>2 weeks</b>		c. CITY OR TOWN <b>CORNING</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5621 Blue Ridge Blvd.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Leon</b> Middle <b>S</b> Last <b>Hitchcock</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1960</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 10, 1885</b>		9. AGE (last birthday) <b>75 yrs</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>SALESMAN MAERICAN SCHOOL</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>BLAIR NEB.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>THOMAS HITCHCOCK</b>				13b. MOTHER'S MAIDEN NAME <b>MARY HURD</b>		14. NAME OF HUSBAND OR WIFE <b>BERTHA HITCHCOCK</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>487 10 0283</b>		17. INFORMANT <b>Mrs. Bertha Hitchcock Corning Iowa</b> Address			
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>Myocardial Degeneration</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</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>3 wks</b> <b>1 year</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 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 <b>April 1, 1958</b> to <b>April 9, 1960</b> and last saw her/him alive on <b>April 9, 1960</b> Death occurred at <b>8:10</b> <b>P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>John K. Caldwell M.D.</b> (Degree or title)				22b. ADDRESS <b>306 E. 12th St. Kansas City, Mo.</b>				22c. DATE SIGNED <b>4/11/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>APRIL 12 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FLORAL HILLS CEM</b>		23d. LOCATION (City, town, or county) <b>KANSAS CITY MO.</b>		(State)	
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS KC. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>4-12-60</b>		26. REGISTRAR'S SIGNATURE <b>Janner Krueger</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Maxine D. Preston

Licensed Embalmer No. 5040

P. O. Address K. C. Mo.

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.