

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018066

FILED VS. MAY 3 1960

STATE FILE NUMBER

ENDED

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Wasey</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Forsyth</u>		Length of stay in 1b <u>2 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>Lakewood Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3308 E 12th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>Corlida</u> Last <u>Kinney</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-1973</u>		9. AGE (last birthday) <u>87</u>		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) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Osteopathy</u>		11. BIRTHPLACE (City and state or country) <u>Clinton, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Unknown</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE _____					
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>Alfred Cooper</u>		Address <u>1506 Brook Creek Rd Kansas City, Mo</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>Hydrostatic Pneumonia</u>													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Bronchitis</u>													
DUE TO (c) <u>Arteriosclerosis, dementia</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 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 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>9-7-57</u> to <u>4-19-60</u> and last saw her alive on <u>4-19-60</u> Death occurred at <u>4-19-60</u> <u>7:10 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Mary King, D.O.</u>						22b. ADDRESS <u>Forsyth, Mo.</u>			22c. DATE SIGNED <u>4-26-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4/21/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>						
24. FUNERAL DIRECTOR <u>Whelchel Chapel, Branson Mo</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-28-60</u>		26. REGISTRAR'S SIGNATURE <u>Relew Campbell</u>					

(Licensed Embalmer's Statement on Reverse Side)

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 Walter Cobb

Licensed Embalmer No. 4731

P. O. Address Branson

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.