

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018723

FILED VS JUN 15 1960

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 101

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>	Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Keameys</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.K.C. Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>R1</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle _____ Last <u>Best</u>			4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1960</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</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>7-28-1887</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Polay Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>u.s.a.</u>
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13a. FATHER'S NAME <u>Zach M. Best</u>	13b. MOTHER'S MAIDEN NAME <u>Elaine Jane Wills</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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>no</u>	17. INFORMANT <u>Everett Best R. Keameys mo</u>	Address <u>R1 Keameys mo</u>
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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>Circulatory failure</u>		<u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pulmonary embolism</u>	<u>1 week</u>
	DUE TO (c) <u>Phlebotrombosis, leg veins</u>	<u>1 week</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>mitral stenosis and insufficiency (rheumatic)</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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from Feb. 1960 to 6-6-60 and last saw <sup>her</sup>him live on 6/6/60  
Death occurred at 10:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. B. Bawler md</u>	22b. ADDRESS <u>Liberty, Mo.</u>	22c. DATE SIGNED <u>6/7/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>	23d. LOCATION (City, town, or county) (State) <u>Polay Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Prucha-Orchard Co. Liberty Mo</u>	ADDRESS <u>Liberty Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-7-60</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>
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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 John Lombard

Licensed Embalmer No. 4448

P. O. Address West

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.