

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019351

FILED VS MAY 24 1960

149

Primary Registration District No. 1002

Registrar's No.

2550

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>26 days</b>		c. CITY OR TOWN <b>Kansas City</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>Trinity Lutheran Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1962 North 30</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BEULAH</b> Middle <b>MAY</b> Last <b>DAGLEY</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1960</b>				
5. SEX <b>Female</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>6/28/1893</b>	9. AGE (last birthday) <b>66</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>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Excelsior Sprgs, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Daniel Gaines</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Maybe</b>			14. NAME OF HUSBAND <del>OR WIFE</del> <b>Clarence C. Dagley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>510-07-2742</b>		17. INFORMANT (Husband) Address <b>Clarence C. Dagley 1962 No. 30th K.C., Kans.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte Imbalance</b> DUE TO (b) <b>Pancreatic Fistula (external) (post op) 9/27/60</b> DUE TO (c) <b>Obstruction of Common bill duct by Calculus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>9 days</b> <b>3 wks.</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 checked="" 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 Month, Day, Year 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>9/23/44</b> to <b>May 6 1960</b> and last saw her alive on <b>May 5 1960</b> Death occurred at <b>12:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Wm. H. Goodson</b> (Degree or title)				22b. ADDRESS <b>730 Prof Bg Kansas City, Mo</b>			22c. DATE SIGNED <b>May 7 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chapel Hill Mem'l Garden</b>			23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kans.</b>			
24. FUNERAL DIRECTOR <b>Werner Mortuary,</b> ADDRESS <b>1734 Washington Bldg. K.C., K.</b>			25. DATE RECD. BY LOCAL REG. <b>May 9, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

DOCUMENT

Wm. H. Goodson  
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Wm H. Goodson  
730 Pro. Bldg.  
VI2-3434

**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 A. C. Werner

Licensed Embalmer No. 259

P. O. Address KCK

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.

WERNER MORTUARY