

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019426

FILED VS JUN 15 1960

149

1002

2869

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>4 1/2 yrs - 6 mo</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>K.C.T.B Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>618 W. 18th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Donnie Glenn Hall</b>			4. DATE OF DEATH Month <b>5</b> Day <b>25</b> Year <b>60</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>4-2-1914</b>	9. AGE (last birthday) <b>48</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Joseph Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Alonzo Hall</b>		13b. MOTHER'S MAIDEN NAME <b>Zola Blanchard</b>		14. NAME OF HUSBAND OR WIFE <b>Rose Hall</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>486-03-3342</b>	17. INFORMANT <b>Rose Hall</b> Address <b>5009 D.E. Apache Ft. Huachuca, Arizona</b>	

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>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) _____		
DUE TO (c) _____		

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	
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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 _____ 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	STATE

21. I attended the deceased from **11-15-58** to **5-25-60** and last saw her/him alive on **5-25-60**  
Death occurred at **6 am** on the date stated above, and to the best of my knowledge, from the causes stated.

SIGNATURE (Inscribed or title) <b>Edward P. Altman M.D.</b>		22b. ADDRESS <b>K.C. - 7th St.</b>	22c. DATE SIGNED <b>5-25-60</b>
23a. BURNING, CREMATION, EMBALMING (Specify)	23b. DATE <b>5-28-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT OLIVE</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO</b>
24. FUNERAL DIRECTOR <b>SHEIL</b>	ADDRESS <b>11924-E 45th St</b>	25. DATE RECD. BY LOCAL REG. <b>5-27-60</b>	26. REGISTRAR'S SIGNATURE <b>Blair Trinchell</b>

DOCUMENT

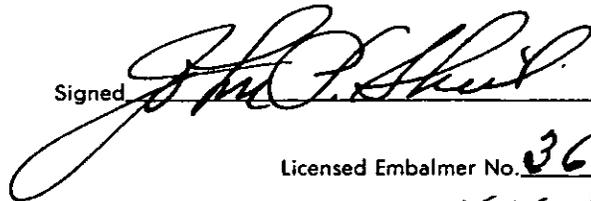
BY AFFIDAVIT OF Edward P. Altman M.D.

**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



Licensed Embalmer No. 3625

P. O. Address 6606 W. 12th

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.