

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

-60-019501

FILED VS MAY 27 1960

147

Primary Registration District No. **1002** Registrar's No. **2698**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS City Length of stay in lb 45 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hosp. # Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson c. CITY OR TOWN KANSAS City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3200 Norledge Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stella Middle C. Last McDermott			4. DATE OF DEATH Month 5 Day 15 Year 60				
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married	8. DATE OF BIRTH Aug 9 1878	9. AGE (last birthday) 81 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) Homemaker		
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Stillwater Minnesota		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME James C. McDermott		13b. MOTHER'S MAIDEN NAME Ann Matthews		14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Harry J Cashman Rawlin Wyoming			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Aspirational Pneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (Cold) Fractured (Right) Hip - Fractured (Left) Femur					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.) Fell at Nursing home			
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 checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
20f. CITY, TOWN, OR LOCATION KANSAS City		20g. COUNTY JACKSON		20h. STATE Mo			
21. I attended the deceased from 5-6-60 to 5-15-60 and last saw her alive on 5-15-60 Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) H. Dwyer M.D.			22b. ADDRESS 2400 Cherry - K.C. Mo		22c. DATE SIGNED 5/16/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/16/1960		23c. NAME OF CEMETERY OR CREMATORY Stillwater Cemetery			
23d. LOCATION (City, town, or county) (State) Stillwater Minnesota		24. FUNERAL DIRECTOR ADDRESS D.W. Newcomers Sons 1331 Brush Creek Blvd. Kansas City Missouri					
25. DATE RECD. BY LOCAL REG. 5-16-60		26. REGISTRAR'S SIGNATURE neva mirahall					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Dwyer

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. _____

P. O. Address _____

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.