

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 24 1960

2544 -60-019690

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_ 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>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 1b <b>62 yrs.</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>Menorah Medical Center</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3048 McGee Trafficway</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Flossie</b> Middle <b>White</b> Last <b>White</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 type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-8-84</b>	9. AGE (last birthday) <b>76</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>Home</b>		11. BIRTHPLACE (City and state or country) <b>Montrose, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Smith</b>			14. NAME OF HUSBAND OR WIFE <b>John B. White</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>490-16-8015A</b>		17. INFORMANT <b>Mrs. Mary Fisher</b> Address <b>Jackson, 975 Graham Rd</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>Right pulmonary embolism, with atelectasis</b> DUE TO (b) <b>Thrombosis, left posterior tibial veins</b> DUE TO (c) <b>Carcinoma, right breast with metastasis to lungs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis, moderate</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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"/> <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ <b>None</b>								
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.) <b>None</b>		20f. CITY, TOWN, OR LOCATION <b>None</b>		COUNTY _____ STATE _____		
21. I attended the deceased from <b>April 27, 1960</b> to <b>May 5, 1960</b> and last saw her/him alive on <b>May 5, 1960</b> Death occurred at <b>12:45 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Irving A. Wien, M.D.</b>				22b. ADDRESS <b>1302 Professional Bldg. Kansas City, Missouri</b>		22c. DATE SIGNED <b>5-8-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/9/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>			
24. FUNERAL DIRECTOR <b>Gates Funeral Home; Kansas City, Kan.</b> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <b>5-8-60</b>		26. REGISTRAR'S SIGNATURE <b>New Marshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Irving A. Wien

**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 Paul R. Williams

Licensed Embalmer No. 5009

P. O. Address Greeland

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.