

VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-022613
STATE FILE NUMBER

FILED VS JUN 30 1960 72 Primary Registration District No. 5289 Registrar's No. 104

1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gladstone</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1405 E. 67th</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clay</u> c. CITY OR TOWN <u>Gladstone</u> d. STREET ADDRESS (If outside, give location) <u>1405 E. 67th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Shelley</u> Middle <u>Dinmore</u> Last <u>Dinmore</u>		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Shelley Dinmore</u>	13c. NAME OF HUSBAND OR WIFE <u>none</u>
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.	17. INFORMANT <u>Edna Dinmore</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, hemorrhagic</u> DUE TO (b) <u>Probably cerebral -</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>DOB</u> <u>HOSP.</u>
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"/> N. <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>State MD Croner</u> (Degree or title)		22b. ADDRESS <u>North Kansas City Mo</u>	
22c. DATE SIGNED <u>6/20/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-19-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miriam Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bothany Mo</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer R.K.S.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-20-60</u>	26. REGISTRAR'S SIGNATURE <u>Marquette Hudgens</u>

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 M. Halusack

Licensed Embalmer No. 4949

P. O. Address No. 1234

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.