

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023134

FILED VS JUN 17 1960 149 Primary Registration District No. 1002 Registrar's No. 3050 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	a. STATE <b>Kansas</b>		b. COUNTY <b>Wyandotte</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>	Length of stay in 1b <b>4 days</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>St Mary's Hospital</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>1640 No 44th St</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First <b>DCRA</b>	Middle <b>LEE</b>	Last <b>DOOLING</b>	Month <b>June</b>	Day <b>6</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>4/26/1926</b>	9. AGE (last birthday) <b>33</b>

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	11. BIRTHPLACE (City and state or country) <b>Kansas City Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Ambrose O'Neal</b>	13b. MOTHER'S MAIDEN NAME <b>Thelma Burkhardt</b>	14. NAME OF HUSBAND OR WIFE <b>Loy Dooling</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>500-20-9538</b>	17. INFORMANT <b>Mr Loy Dooling 1640 No 44th Kansas City Kn</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
IMMEDIATE CAUSE (a)	<b>Carcinoma of ovary - metastatic</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Pleural effusion &amp; ascites</b>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **6-2-60** to **6-6-60** and last saw her alive on **6-6-60**  
Death occurred at **St. Mary's Hospital 666 11 3/4** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert J. Wertenmann, M.D.</b>	22b. ADDRESS <b>425 E 63rd K C 10 MO</b>	22c. DATE SIGNED <b>6-7-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 8 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Kansas</b>
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24. FUNERAL DIRECTOR <b>John P Sheil Kansas City Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>6-7-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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DOCUMENT BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF DOCUMENT

Dr. Worthman  
425 863rd St

**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

*James A. Smith*

Licensed Embalmer No. 1954

P. O. Address J. C. M.

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.