

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023418

FILED VS JUL 5 1960

149

Primary Registration District No. 1002

Registrar's No.

3222

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Miami			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 2 days	c. CITY OR TOWN Paola, Kansas		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 210 East Shawnee		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Steffen Last			4. DATE OF DEATH Month June Day 15 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/18/82	9. AGE (last birthday) 77	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Non		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Unknown St. Marys Hospital Records			
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	
IMMEDIATE CAUSE (a) Subdiaphragmatic abscess and empyema - right chest.					Unknown	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Chronic cholecystitis and cholelithiasis and empyema of gallbladder.	
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	
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		COUNTY	STATE
21. I attended the deceased from June 13, 1960 , to June 15, 1960 and last saw he alive on June 14, 1960 Death occurred at 6:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Name or title) J. E. Castles M. D.			22b. ADDRESS 1002 Argyle Bldg., 306 E. 12th St. Kansas City 6, Missouri		22c. DATE SIGNED 6-17-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 17, 1960	23c. NAME OF CEMETERY OR CREMATORY Paola Cemetery		23d. LOCATION (City, town, or county) Paola, Kansas		(State)
24. FUNERAL DIRECTOR ADDRESS Gates F. H. 1901 Olathe Buld., Kansas City 3, Kan			25. DATE RECD. BY LOCAL REG. 6-17-60	26. REGISTRAR'S SIGNATURE Neva Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF J. E. Castles

(Licensed Embalmer's Statement on Reverse Side)

Dr. P. ...
Argyle ...
1-5037

OCT 19 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Murray Wilson*

Licensed Embalmer No. *490*

P. O. Address *Perkins*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.