

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 26 1960

-60-026823

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3641

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAY</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY, Mo.</u>		Length of stay in lb <u>10 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>OSTOPATHIC HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4336 NORTH CLEVELAND</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>MRS. HELOISE MAIRIE DUCOMMUN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>12</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 7 1929</u>	9. AGE (last birthday) <u>31</u>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAYTAG LAUNDRY</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO. LAUNDRY N.K.C. Mo.</u>		11. BIRTHPLACE (City and state or country) <u>LADYSMITH, Wisc.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>GEORGE ZIMMER</u>			13b. MOTHER'S MAIDEN NAME <u>ALICE SCHWALEN</u>			14. NAME OF HUSBAND OR WIFE <u>EUGEN A. DUCOMMUN</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. <u>389-28-2102</u>		17. INFORMANT <u>EUGENE A. DUCOMMUN</u>			Address <u>4336 N. CLEVELAND K.C., Mo. NORTH</u>	
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>Respiratory failure</u> DUE TO (b) <u>Adrenocortical Insufficiency</u> DUE TO (c) <u>Operation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</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"/> 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. _____			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 <u>7-11-60</u> to <u>7-12-60</u> and last saw her <u>alive</u> on <u>7-12-60</u> . Death occurred at <u>Ostopathic Hospital</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>D. W. Newbomer, D.O.</u> (Degree or title)				22b. ADDRESS <u>409 Wirthmer St.</u>				22c. DATE SIGNED <u>7-13-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>JULY 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEMETERY</u>			23d. LOCATION (City, town, or county) <u>LADYSMITH Wisc.</u>			
24. FUNERAL DIRECTOR <u>D. W. NEWBOMER'S SONS N.K.C., Mo.</u>				ADDRESS <u>N.K.C., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-13-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minchall</u>	

DOCUMENT

BY AFFIDAVIT OF OSTOPATHIC HOSPITAL W. MO. MEDICAL CERTIFICATION

A. L. JOHNSON - D. G.
GASLAND. MO.

6 - COPIES

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 W. Kalsbeek

Licensed Embalmer No. *4949*

P. O. Address *No. Kansas*

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.