

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026914

FILED VS AUG 8 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3785

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 23		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3108 Cypress			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3108 Cypress			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle G. Last HINES				4. DATE OF DEATH Month July Day 20 Year 1960					
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1891	9. AGE (last Birthday) 68		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (retired)		10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hospital		11. BIRTHPLACE (City and state or country) Lawrenceburg, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Frank Hines			13b. MOTHER'S MAIDEN NAME Jane Bell			14. NAME OF HUSBAND OR WIFE Myrtle Hines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 409-03-255V		17. INFORMANT Robert D. Hines, 6408 E87				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis								INTERVAL BETWEEN ONSET AND DEATH 96 hrs	
DUE TO (b) Cerebral arteriosclerosis								5 yrs	
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)							
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 April 9, 1957 to July 20, 1960 and last saw him alive on July 17, 1960 Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Howard E. Linville M.D. (Degree or title)				22b. ADDRESS 8103 Grand Ave, Kansas City, Mo				22c. DATE SIGNED 7-22-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 23/7/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetary		23d. LOCATION (City, town, or county) (State) Kansas City Mo.				
24. FUNERAL DIRECTOR Melody McGilley Eylar ADDRESS 1800 E. Linwood K.C. Mo				25. DATE RECD. BY LOCAL REG. 7-22-60		26. REGISTRAR'S SIGNATURE Neva Marshall			

DOCUMENT

BY AFFIDAVIT OF
Howard E. Linville
MEDICAL CERTIFICATION

Dr. Howard
Prof. Bell
Ma 1-6'6

1:30 P-5PM

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 *Dale L. Martin*

Licensed Embalmer No. *510*

P. O. Address *Shawnee*

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.