

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JUL 26 1960

**=60-026934**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3390 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>2 1/2 mo. 4 1/2 yrs</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>Northeast Osteopathic Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3832 Denton Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDNA JENKINS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1960</b>							
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1881</b>		9. AGE (last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
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 <b>-</b>		11. BIRTHPLACE (City and state or country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>L.W. Bice</b>				13b. MOTHER'S MAIDEN NAME <b>Edna Rae</b>				14. NAME OF HUSBAND OR WIFE <b>Paul Jenkins</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>-</b>		17. INFORMANT Address <b>Iver Donald Jenkins, K.C.Mo.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Adenocarcinoma of uterus with metastasis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
IMMEDIATE CAUSE (a) <b>Cause unknown</b>											
DUE TO (b) <b>None</b>											
DUE TO (c) <b>None</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>								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 Month, Day, Year 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 <b>April 16, 1959</b> to <b>June 27, 1960</b> and last saw her <sup>her</sup> alive on <b>June 27, 1960</b> Death occurred at <b>6:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <b>Frank E. Day D.O.</b> (Degree or title)				22b. ADDRESS <b>4314 E. 9th St. K.C. Mo.</b>				22c. DATE SIGNED <b>6-28-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-28-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>-</b>		23d. LOCATION (City, town, or county) <b>Butler, Missouri</b>		(State)			
24. FUNERAL DIRECTOR <b>Stine &amp; McClure, K.C.Mo.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>6-28-60</b>		26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank E. Day

AS AUG 8 1886

Statement of facts to be furnished

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Orel Robinson

Licensed Embalmer No. 4232

Address H.C. 7th

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.