

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027030

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STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3853

ENDED
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF M. Hillman

| | | | | | | |
|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 10 Yrs. | 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 General Hospital #1 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1800 East 13th | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Corine Middle Venice Last Mitchell | | | 4. DATE OF DEATH Month 7 Day 24 Year 60/60 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Unknown | 9. AGE (last birthday) 52 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress | | 10b. KIND OF BUSINESS OR INDUSTRY Laundry | 11. BIRTHPLACE (City and state or country) Topeka, Kansas | | 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 None | | |
| 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. None | 17. INFORMANT Address Elizabeth Stanley, Topeka, Kas | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock Hemorrhagic DUE TO (b) Internal Thoracic Hemorrhage DUE TO (c) Penetrating Stab Wound of Chest. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) don't know | | | | |
| 20c. TIME OF INJURY 2:45 p.m. | Month, Day, Year 7/24/60 | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1800 E 13 | 20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, MO | | COUNTY | STATE | |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE Deputy Coroner | | | 22b. ADDRESS 1618 Lydia Ave. | | 22c. DATE SIGNED 7/25/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 7-30-60 | 23c. NAME OF CEMETERY OR CREMATORY Mount Auburn | 23d. LOCATION (City, town, or county) Topeka, Kansas | | (State) | |
| 24. FUNERAL DIRECTOR Lawrence A. Jones | | ADDRESS 2304 Vine | 25. DATE RECD. BY LOCAL REG. 7-26-60 | 26. REGISTRAR'S SIGNATURE Neva Marshall | | |

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.