

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

**=60-027031**

**FILED VS AUG 8 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3702

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital #2</u>		Length of stay in 1b OR <u>Life</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3339 Colorado</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
--	--	---	--	--

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Infant</u> Middle Last <u>Mitchell</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>3</u> Year <u>1960</u>		
--	--	--	---	--	--

<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-3-60</u>	<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours <u>5</u> Min. _____
------------------------------	---	---	--	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Kansas City, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>
---	--	---	---

<b>13a. FATHER'S NAME</b> <u>Infant</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary Fletcher</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>none</u>
--	--	---

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	<b>17. INFORMANT</b> Address <u>Mary Mitchell 3339 Colorado</u>
--	---	--

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ 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
---	--

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
--	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____
--

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
---	---	--

21. I attended the deceased from 7-3-60 to 7-3-60 and last saw her/him alive on 7-3-60  
 Death occurred at 3:45 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)	<b>22b. ADDRESS</b> <u>600 East 22nd Street</u>	<b>22c. DATE SIGNED</b> <u>7-15-60</u>
--	--	---

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>7-19-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Graves</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City MO</u>
---	------------------------------------	--	---

<b>24. GENERAL DIRECTOR</b> ADDRESS <u>[Signature] KC MO</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-16-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>
---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank Ellis

**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 Not Embalmed, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Anna L. Sawyer

Licensed Embalmer No. 308

P. O. Address FC

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.