

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

=60-027043

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3874

IDED

|   |  |   |  |  |  |   |       |
|---|--|---|--|--|--|---|-------|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |  |   |       |
| a. COUNTY<br><b>Jackson</b>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Kansas City</b>   |  | a. STATE<br><b>Missouri</b>  |  | b. COUNTY<br><b>Jackson</b>   |       |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>3913 Denver</b>   |  | Length of stay in 1b<br><b>36 yrs.</b>  |  | c. CITY OR TOWN<br><b>Kansas City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |       |
| d. STREET ADDRESS<br><b>3913 Denver</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location)<br><b>3913 Denver</b>                          |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MRS. ALMA NANCE</b>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 26, 1960</b>                                   |  |   |       |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-13-1876</b>           | 9. AGE (last birthday)<br><b>83</b>  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Wickliff, Kentucky</b>                      |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |       |
| 13a. FATHER'S NAME<br><b>William H. Harding</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Emma T. Nance</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Pressley U. Nance</b>                                      |  |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Mrs. Joetta Akins 3913 Denver</b>  |  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon</b>  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b>                                      |       |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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 <b>March 1960</b> to <b>July 26, 60</b> and last saw her <sup>her</sup> alive on <b>July 25, 60</b><br>Death occurred at _____ <b>9:52</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |   |       |
| 22a. SIGNATURE (Degree or title)<br><b>Harold W. Voth, M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>201 Plaza Med. Bldg. Kansas City, Mo.</b>                                 |  | 22c. DATE SIGNED<br><b>July 27, 60</b>  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 23b. DATE<br><b>28 Aug 60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>-</b> |  | 23d. LOCATION (City, town, or county) (State)<br><b>Humansville, Missouri</b>  |   |       |
| 24. FUNERAL DIRECTOR<br><b>Melody McGilley Eylar Funeral Home</b><br><b>1000 E. Linwood Blvd.</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>7-27-60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Neva Minshall</b>                                     |       |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Harold W. Voth

Dr. Harold  
Oliza Me  
VA 1-3243

anytime

**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. 5106

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.