

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027067

FILED VS AUG 15 1960 147

Registration District No.

Primary Registration District No. 1002

Registrar's No.

3720

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>Kansas</b> b. COUNTY <b>Johnson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>3 months</b>		c. CITY OR TOWN <b>Leawood</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3918 Charlotte</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2819 W. 92nd St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>F.</b> Last <b>PATTON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</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>6-9-1874</b>		
9. AGE (last birthday) <b>86</b>		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) <b>Sales Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (City and state or country) <b>Roanoke, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Eonrad Feiring</b>			13b. MOTHER'S MAIDEN NAME <b>Katherine Fuhrman</b>			14. NAME OF HUSBAND OR WIFE <b>James R. Patton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>486-07-4515</b>		17. INFORMANT <b>Mrs. Russell May</b>			
			Address <b>Leawood, Kansas</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <b>Arteriosclerotic C.V. disease.</b> DUE TO (b) <b>Arteriosclerotic C.V. disease.</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b></b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH <b>2+ years</b> <b>15 yrs.</b>	
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.) <b></b>				
20c. TIME OF INJURY Hour <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>								
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.) <b></b>		20f. CITY, TOWN, OR LOCATION <b></b>		COUNTY <b></b> STATE <b></b>		
21. I attended the deceased from <b>Sept 1955</b> to <b>July 17 1960</b> and last saw her <b>him</b> alive on <b>July 16 1960</b> Death occurred at <b>9:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Frank B. Leitz</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>1530 Prof Bldg Kansas City Mo</b>		22c. DATE SIGNED <b>7-18-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 20, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roanoke Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Roanoke Missouri</b>		
24. FUNERAL DIRECTOR <b>Roland R. Speaks</b> ADDRESS <b>Independence, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7-18-60</b>		26. REGISTRAR'S SIGNATURE <b>meva Marshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Frank B. Leitz

**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

*Wayne Smith*

Licensed Embalmer No. 5081

P. O. Address Indep. 7

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co  
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.