

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029956

STATE FILE NUMBER

SEP
DED

Registration District No. 22 Primary Registration District No. 3013 Registrar's No. 130

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORTH KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>1 hour</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4300 E. 49TH ST</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>MAY</u> Last <u>HANKINS</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1915</u>	9. AGE (last birthday) <u>44</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER - BANKING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (City and state or country) <u>MACON, Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>D.W. SLOAN</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZA CRUI</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM V. HANKINS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>497-01-7030</u>		17. INFORMANT <u>WILLIAM V. HANKINS</u>			Address <u>4900 E 49TH K.C. MO.</u>

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hr Min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of breast (previously operated) with metastasis to lung and bone</u>		3 years	
DUE TO (c) <u>lung and bone</u>			
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"/> N: <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. 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
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21. I attended the deceased from August 19, 1960 to August 23, 1960 and last saw her alive on August 23, 1960
Death occurred at 5:20p on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE <u>John B Withrow</u>		22b. ADDRESS <u>2730. S Mall Kansas City Mo</u>		22c. DATE SIGNED <u>August 24, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MACON, Mo.</u>	
24. FUNERAL DIRECTOR <u>D.W. Newcomer's sons</u>		ADDRESS <u>N.K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-24-60</u>	
				26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

John V. Kenick

Licensed Embalmer No. 489

P. O. Address K.C. 17

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.