

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 12 1960

149

4408-60-030578

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Length of stay in 1b <b>50 Yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hosp.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>439 East 64th Terr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Myrtle</b> Last <b>Haver</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>27</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-3-90</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sect. - Pres.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Haver Glover Laboratories</b>		11. BIRTHPLACE (City and state or country) <b>Sweet Springs, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Cahill</b>			13b. MOTHER'S MAIDEN NAME <b>Alice Burch</b>			14. NAME OF HUSBAND OR WIFE <b>Clifford V. Haver</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>486-01-0748</b>		17. INFORMANT Address <b>K.C.MO.</b> <b>Clifford V. Haver 439 East 64th Terr.</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>metastatic adenocarcinoma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Adenocarcinoma of Rectum</b>								
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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 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	
21. I attended the deceased from <b>8/11/59</b> to <b>8/27/60</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>8/27/60</b> . Death occurred at <b>10:15</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>J. Cutcliff MD</b>				22b. ADDRESS <b>1222 McPhe</b>		22c. DATE SIGNED <b>8/28/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Aug. 29 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hiawatha Kansas</b>			
24. FUNERAL DIRECTOR <b>D.W. Newcomers; Sons Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-28-60</b>		26. REGISTRAR'S SIGNATURE <b>H-S-Dwyer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. Cutcliff

**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 Kern Lawler

Licensed Embalmer No. 4912

P. O. Address K.G. Mc

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.