

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030681

FILED VS AUG 29 1960

149

Registration District No. Primary Registration District No. 1002

Registrar's No. 4111

STATE FILE NUMBER

ENDED

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> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>10 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>Armour Memorial Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8100 Wornall Rd.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Mary</b> Last <b>Marbut</b>			4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1960</b>		
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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>Jan. 8, 1877</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mt. Vernon, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>J. A. Cochran</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Frances Poage</b>	14. NAME OF HUSBAND OR WIFE <b>John F. Marbut</b>
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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>None</b>	17. INFORMANT <b>Elizabeth R. Schreiber, Kansas City, Mo.</b>	Address
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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>Respiratory Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Metastatic Carcinoma to Brain</b>	<b>2 mos</b>
	DUE TO (c) <b>Rectal Carcinoma</b>	<b>1 year</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malnutrition</b>		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	
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 <b>Kansas City, Missouri</b>	COUNTY	STATE
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21. I attended the deceased from **Jan 1 60** to **present** and last saw her alive on **8/9/60**  
Death occurred at **Kansas City, Mo** at **7 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George K Boyd M.D.</b> (Degree or title)	22b. ADDRESS <b>1630 Professional Bldg KC</b>	22c. DATE SIGNED <b>8/9/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-11-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8-10-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dwyer</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

George K. Boyd

**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 William M. Jones

Licensed Embalmer No. 467  
P. O. Address Kansas City

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.