

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

=60-030717

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4023 STATE FILE NUMBER

INDEXED

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|--|--|---|--|---|---|--|---|--|-----------------------------------|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 9 yrs. | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1025 Fuller | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Marguerite Middle Nicolary Last Nicolary | | | | 4. DATE OF DEATH Month August Day 4 Year 1960 | | | | | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5/18/1912 | | 9. AGE (last birthday) 48 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (City and state or country) Bevier, Missouri | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | | |
| 13a. FATHER'S NAME Charles Adams | | | | 13b. MOTHER'S MAIDEN NAME Mae Walkup | | | | 14. NAME OF HUSBAND OR WIFE Thomas J. Nicolary | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 491-14-2179 | | 17. INFORMANT Address Thomas J. Nicolary 1025 Fuller | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Paralytic ileus DUE TO (c) Peritonitis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 3 weeks | | | |
| 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 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 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 7-9-60 to 8-4-60 and last saw her/him alive on 8-4-60 Death occurred at 12:12 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) E.D. Reese | | | | | | 22b. ADDRESS 3309 E 12 | | | 22c. DATE SIGNED 8-5-60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Aug. 6, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery | | | | 23d. LOCATION (City, town, or county) Bevier, Missouri | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Earp & Sons Kansas City, Missouri | | | | 25. DATE RECD. BY LOCAL REG 8-5-60 | | 26. REGISTRAR'S SIGNATURE H-L-Dwyer, M.D. | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

E.D. Reese

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 H. Eary

Licensed Embalmer No. 4728

P. O. Address H. C. 7

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.