

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 30 1960

=60-030919

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 409

NDED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 76 Yrs		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If in institution, give location) HOSPITAL OR INSTITUTION Baptist Convalescence Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 500 Truman Road		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DELSIA Middle A. Last SIMPSON				4. DATE OF DEATH Month August Day 22 Year 1960					
5. SEX Female		6. COLOR OR RACE Negro		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-10-94		9. AGE (last birthday) 66 Yrs. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
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) Independence, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE *****			
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. -----		17. INFORMANT Address Rev. P. Allen, Sr. K. C. Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac decompensation DUE TO (c) Cardiac hypertrophy							INTERVAL BETWEEN ONSET AND DEATH Hours Days Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis, paraplegia.							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		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 April 16, 1958 , to Aug. 22, 1960 and last saw her ^{her} alive on Aug. 17, 1960 Death occurred at 3:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Sarahy N. Nathaniel M.D.				22b. ADDRESS 809 N. Lexington Independence, Mo.				22c. DATE SIGNED 8/24/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-26-60		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
24. FUNERAL DIRECTOR ADDRESS Mrs. Meek's Mortuary K. C. Mo.			25. DATE RECD. BY LOCAL REG. 8-26-60		26. REGISTRAR'S SIGNATURE Jamers [Signature]				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 19 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Millard B. [Signature]

Licensed Embalmer No. 50

P. O. Address K. C.

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