

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034196

FILED VS SEP 21 1960

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 141

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Village of Oak</u>		c. CITY OR TOWN <u>Village of Oak</u>	
Length of stay in 1b <u>2 yrs</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>Compton Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>5851 N. Barnes</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>Mrs Bertha M</u> Middle <u>Richardson</u> Last <u></u>			4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1960</u>			
--	--	--	---	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-1877</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
----------------------	-------------------------------	--	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (City and state or country) <u>Webster Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
--	--	--	---

13a. FATHER'S NAME <u>John D Wiltse</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Best</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</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>none</u>	17. INFORMANT Address <u>R.K. Harton 7308 Cherokee</u>
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		<u>9 years</u>
DUE TO (c) <u></u>		<u></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 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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>
---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1-1-60 to 9-13-60 and last saw her alive on 9-13-60  
Death occurred at 12 noon on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <u>Frank Paul Lawrence MD</u>	22b. ADDRESS <u>428 S White Ave</u>	22c. DATE SIGNED <u>9-13-60</u>
--	-------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-15-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City MO</u>
---	--------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Wornall Funeral Home Inc Kcmo</u>	25. DATE RECD. BY LOCAL REG. <u>9-14-60</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>
---	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 21 1960

### 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 Russell N. Frank

Licensed Embalmer No. 425

P. O. Address K.C. Mo

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.