

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034745

FILED VS OCT 14 1960

1956

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

NDED

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|---|--|--|--|---|---|--|---|---|------------------------------------|--|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb Life | | 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 DOA St. Joseph's Hosp. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 4401 E. 9th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Bobb y Middle Dean Last Frame | | | | 4. DATE OF DEATH Month 9 Day 30 Year 1960 | | | | | | | | | |
| 5. SEX Male | | 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 3/9/1938 | | 9. AGE (last birthday) 27 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | | | 10b. KIND OF BUSINESS OR INDUSTRY Centropolis Crusher Kansas Coty Mo | | | | 11. BIRTHPLACE (City and state or country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY | | | |
| 13a. FATHER'S NAME Claud Frame | | | | 13b. MOTHER'S MAIDEN NAME Rosebell Mundy | | | | 14. NAME OF HUSBAND OR WIFE Patricia Frame | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean | | | | 16. SOCIAL SECURITY NO. 490-34-0317 | | | | 17. INFORMANT Patricia Frame Address 4401 E 9th St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & Hemorrhage DUE TO (b) resulting from crushing injuries of DUE TO (c) chest, abdomen & head Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 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"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) Crushed by rocks. | | | | | | | | | |
| 20c. TIME OF INJURY Hour 9:30 Month, Day, Year 10-30-60 | | 20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) quarry | | 20f. CITY, TOWN, OR LOCATION Kansas city | | COUNTY Jackson | | STATE Mo | | | |
| 21. I attended the deceased from _____, to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22. SIGNATURE (Degree or title) Dr. C. Kealhofer, Int. Deputy Coroner | | | | | | 22b. ADDRESS 6627 Park St. St. Louis | | | 22c. DATE SIGNED 10-1-60 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10/3/60 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | | 23d. LOCATION (City, town, or county) (State) Independence Mo | | | | | | |
| 24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo | | | | 25. DATE RECD. BY LOCAL REG. 10-3-60 | | 26. REGISTRAR'S SIGNATURE H-L. Dwyer | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF C. Kealhofer

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 Richard E. Carroll

Licensed Embalmer No. 422

P. O. Address K.C.M.

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