

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

0-034778  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4683

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Missouri</b>		Length of stay in lb <b>25 Years</b>	c. CITY OR TOWN <b>4033 Park, 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>General Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4033 Park</b>		
3. NAME OF DECEASED (Type or print) <b>Mr. Theodore R. Haase</b>			First	Middle	Last	
4. DATE OF DEATH <b>9 - 7 - 1960</b>			Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1910</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Awning Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Independent</b>	11. BIRTHPLACE (City and state or country) <b>Joplin, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Madie Haase</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W. W. 2</b>		16. SOCIAL SECURITY NO. <b>491-07-8038</b>	17. INFORMANT Address <b>Madie Haase 4033 Park Kansas City, Mo.</b>			
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>Fractured Skull Subdural Hematoma</b> DUE TO (b) <b>Fracture of Cranial Base</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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					INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 or item 18.) <b>Fell on sidewalk. Had history of falling off ladders, etc. previously</b>				
20c. TIME OF INJURY Hour Month, Day, Year <b>9-7-60</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., of about home, farm, factory, street, office bldg., etc.) <b>Kans City Jackson Mo</b>	20f. CITY, TOWN, OR LOCATION <b>Kans City Jackson Mo</b>	COUNTY	STATE	
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.						
22a. SIGNATURE (Degree or title) <b>Hugh H. Owens Coroner</b>			22b. ADDRESS <b>152 Union Station</b>		22c. DATE SIGNED <b>9-14-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-10-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel Mem. Gardens Gladstone, Missouri</b>	23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR <b>D. W. Newcomer's Sons</b>		ADDRESS <b>North Kansas City</b>	25. DATE RECD. BY LOCAL REG. <b>9-13-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
HUGH H. OWENS

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John W. Herrick, Jr.

Licensed Embalmer No. 4898

P. O. Address N. C. 17, 7m

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