

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-034819

ENDED

FILED VS SEP 20 1960

149

Primary Registration District No. 1002

Registrar's No.

4459

STATE FILE NUMBER

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) <b>Jackson</b>		Length of stay in 1b <b>45 yrs.</b>	c. CITY OR TOWN <b>Kansas City, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital give location) <b>Albritton Nurs. Home.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1010 E. 18th.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Homer Hudgins</b>			4. DATE OF DEATH Month Day Year <b>8 29 60-30</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/92</b>	9. AGE (last birthday) <b>68 yrs.</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>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hamilton Mo.</b>	11. BIRTHPLACE (City and state or country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <del>XXXXXXXXXX</del>		13b. MOTHER'S MAIDEN NAME <b>HUDGINS Maria Hudgins</b>		14. NAME OF HUSBAND OR WIFE <b>Des Moines</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>W W I</b>		16. SOCIAL SECURITY NO. <b>495-07-7133</b>	17. INFORMANT <b>Ethel G. Fletcher II 39 W. 9th</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>Cerebral Vascular Accident</b> DUE TO (b) <b>Generalized arteriosclerosis with left hemiparesis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Benign prostatic hypertrophy</b> 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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>neither</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>none</b>			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>None</b>					
20d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK <b>not at work</b>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. CITY, TOWN, OR LOCATION <b>KANSAS CITY, JACKSON, MISSOURI</b>		
21. I attended the deceased from <b>25 July 60 to 29 Aug 60</b> and last saw him alive on <b>28 Aug '60</b> Death occurred at <b>15 30/A</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>John H. Wells MD</b>		(Degree or title)	22b. ADDRESS <b>3718 Prospect</b>		22c. DATE SIGNED <b>30 Aug '60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/2/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Ft. Leavenworth Kansas</b>	
24. FUNERAL DIRECTOR <b>Manlove-Williams</b>		ADDRESS <b>1729 Lydia</b>	25. DATE RECD. BY LOCAL REG. <b>8-31-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF: John H. Wells

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed

*Maynard Keller*

Licensed Embalmer No. 46515

P. O. Address J.C. Row

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.