

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034822

FILED VS SEP 20 1960 149

Registration District No. 1002 Registrar's No. 4521

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>KANSAS</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>Homewood</b>	
Length of stay in 1b <b>11 DAYS</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>Doctor's Hospital</b>		d. STREET ADDRESS (If outside, give location) 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 <b>ELMINA</b> Middle <b>None</b> Last <b>HURLEY</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>5</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1885</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Annabelle Slaughter</b>		14. NAME OF HUSBAND OR WIFE <b>George Hurley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or if unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>513-36-5433</b>	17. INFORMANT Address <b>Mrs. Morris C. Jones, Seattle Wash.</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>pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>5 yrs.</b>
DUE TO (b) <b>Myocarditis</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>adenocarcinoma of uterus</b>		PART III. Deceased was female was pregnant 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 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 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 **8-25-60** to **9-5-60** and last saw her alive on **9-4-60**  
 Death occurred at **9** **4:08 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>F. W. Thompson DO.</b>		22b. ADDRESS <b>2501 Gillham Rd</b>		22c. DATE SIGNED <b>9-5-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-5-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OTTAWA KANSAS</b>		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>LAMB MORTUARY, OTTAWA, KANSAS</b>		25. DATE RECD. BY LOCAL REG. <b>9-4-60</b>	26. REGISTRAR'S SIGNATURE <b>H-L. Dwyer</b>	

DOCUMENT

F. W. Thompson MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.