

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

149

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

4735-60-034835
STATE FILE NUMBER

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>55 YEARS</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5227 Brighton Avenue</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5227 Brighton Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ESTELLE</u> Middle <u>JOHNSON</u> Last _____ | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>16,</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>SEPT. 17, 1883</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (City and state or country) <u>LEAVENWORTH, KANSAS</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | |
| 13a. FATHER'S NAME <u>LINTON TUTTLE</u> | | 13b. MOTHER'S MAIDEN NAME <u>HELEN ANDERSON</u> | | 14. NAME OF HUSBAND OR WIFE <u>HARRY JOHNSON</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>2526 SOUTH 13TH ST. KANSAS CITY, KANSAS</u> <u>MRS. VIRGINIA MORETINE</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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | 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"/> 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 _____ a.m. _____ p.m. 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 <u>1:00 A.</u> , to _____ and last saw her/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) <u>Hugh H. Owens Coroner</u> | | | 22b. ADDRESS <u>152 Union Station</u> | | 22c. DATE SIGNED <u>9-16-60</u> | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>SEPT. 17, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORIUM <u>MOUNT MUNCIE CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State) <u>LEAVENWORTH KANSAS</u> | | | |
| 24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS</u> | | 25. DATE RECD. BY LOCAL REG. <u>9-17-60</u> | | 26. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u> | | | |

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. L. Gibson

Licensed Embalmer No. 4137

Excelsior, Mo.

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