

**IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-034840**

**FILED VS SEP 20 1960**

Registration District No. 149 Primary Registration District No. 100a Registrar's No. 4462 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>	a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>	Length of stay in lb <b>2 weeks</b>	c. CITY OR TOWN <b>KANSAS CITY 21</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>MENORAH HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10006 LEXINGTON</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)	First <b>KATHRYN</b>	Middle <b>ELEANOR</b>	Last <b>JONES</b>	<b>4. DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>30</b> Year <b>1960</b>
---	----------------------	-----------------------	-------------------	---

<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-3-1914</b>	<b>9. AGE (last birthday)</b> <b>46</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
--------------------------------	---	---	--	--	---	---

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>DOMESTIC</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>JACKSON COUNTY, MO.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
--	---	---	---

<b>13a. FATHER'S NAME</b> <b>EUGENE L. REINHART</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>KATHRYN HYDE</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>SIDNEY L. JONES</b>
--	---	--

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	<b>16. SOCIAL SECURITY NO.</b> <b>494-30-7981</b>	<b>17. INFORMANT</b> <b>Sidney L. Jones, 10006 Lexington, K.C. 21, Mo.</b>	<b>Address</b>
--	--	---	----------------

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <b>Status asthmaticus</b>		<b>5 days</b>
DUE TO (b) <b>bronchial asthma</b>		<b>3 years</b>
DUE TO (c)		

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
---	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____
--

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
--	---	--

**21. I attended the deceased from** 23 May 1960 **to** 30 August 1960 **and last saw her/him alive on** 30 August 1960  
**Death occurred at** 4:35 **o** 8 **m on the date stated above, and to the best of my knowledge, from the causes stated.**

<b>22a. SIGNATURE</b> <i>Stanley L. Goldman</i> (Degree or title)	<b>22b. ADDRESS</b> <b>751 E 63 St Kansas City, Mo</b>	<b>22c. DATE SIGNED</b> <b>8/31/60</b>
--	---	---

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>23b. DATE</b> <b>9-2-60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. OLIVET CEMETERY</b>	<b>23d. LOCATION (City, town, or county)</b> <b>KANSAS CITY, MO.</b>
---	-----------------------------------	---	---

<b>24. FUNERAL DIRECTOR</b> <b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-31-60</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>H. L. Dwyer</i>
--	---	--

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF Stanley L. Goldman

**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 Dean W. Huff

Licensed Embalmer No. 4916

P. O. Address Indy, IN

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