

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-034855

FILED VS OCT 14 1960

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

5000

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. 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>4 da -</u>		c. CITY OR TOWN <u>Kansas City -</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>209 W-38th -</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>MAUDE</u> Last <u>KILLINGER</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>2</u> Year <u>1960</u>									
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUC</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>7/20/1890</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>LEONARD, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>CHARLES GARNET</u>				13b. MOTHER'S MAIDEN NAME <u>CATHERINE VANDERWER</u>				14. NAME OF HUSBAND OR WIFE <u>CHARLES G. KILLINGER</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>-</u>				17. INFORMANT <u>MARIE MILDRED JONES.</u> Address <u>NOBLETY, MO.</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>Pulmonary Edema</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u>										<u>24 hours</u>			
DUE TO (c) <u>Shock of fracture right arm 2 ribs</u>										<u>10 days</u>			
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 checked="" 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"/>		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 a.m. p.m.													
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>4:00</u> <u>6-24-59</u> to <u>10-2-60</u> and last saw her <u>alive</u> on <u>10-2-60</u> Death occurred at <u>4:00</u> <u>p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title)						22b. ADDRESS <u>3 East 39th St, Kansas City, Mo</u>			22c. DATE SIGNED <u>10-5-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
<u>Removal</u>		<u>10-4-60</u>		<u>-</u>				<u>Edina, Mo</u>					
24. FUNERAL DIRECTOR <u>Hudson-Kamer Mortuary, Edina, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-5-60</u>				26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Chris G. Stephens

06T 14 1960

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

John R. [Signature]

Licensed Embalmer No. 4531

P. O. Address Kansas

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.

66-72-01