

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 0 1960

4551-60-034894
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PLATTE					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 5 yrs.		c. CITY OR TOWN PARKVILLE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR 3537 MAIN STREET INSTITUTION LINDEMAN NURSING HOME			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) WEATHERBY LAKE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIBALD W. MACKIE, JR.				4. DATE OF DEATH Month Day Year SEPTEMBER 2 1960					
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH MAY 2, 1910		9. AGE (last birthday) 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY COMBUSTION EQUIPMENT COMPANY		11. BIRTHPLACE (City and state or country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME ARCHIBALD W. MACKIE, SR.			13b. MOTHER'S MAIDEN NAME ANN TUTT			14. NAME OF HUSBAND OR WIFE MRS. STELLA J. MACKIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 487-10-1792		17. INFORMANT MRS. STELLA J. MACKIE Address 4528 BROADWAY KANSAS CITY, MO.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Cerebral Arteriosclerosis, Hypertension DUE TO (c) _____ 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"/> No <input type="checkbox"/> Unknown							INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
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 June 1953 to Sept 2, 1960 and last saw him alive on Aug 20, 1960 Death occurred at 11:10 P m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Robert W. Hamill, M.D.				22b. ADDRESS Kansas City Mo				22c. DATE SIGNED 9/3/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE SEPT 6, 1960		23c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI			
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS Address 1331 BRUSH CREEK KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. 9-6-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer				

DOCUMENT

BY AFFIDAVIT OF Robert W. Hamill, M.D. MEDICAL CERTIFICATION

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 Cherita K. Brown

Licensed Embalmer No. 19

P. O. Address 102

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.