

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034942

FILED VS. OCT 14 1960

149

Primary Registration District No. 1002 Registrar's No. 4896

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>Mo.</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 years</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1529 Lexington Court</u>				d. STREET ADDRESS (If outside, give location) <u>1529 Lexington Court.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Inez</u> Last <u>Neill</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-1897</u>	
9. AGE (last birthday) <u>62</u>		IF UNDER 1 YEAR Months _____ Days _____		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 <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Monticello, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				13a. FATHER'S NAME <u>John Bates</u>			
13b. MOTHER'S MARDEN NAME <u>Katherine O'Neil</u>				14. NAME OF HUSBAND OR WIFE <u>Robert Neill</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>unknown</u>		17. INFORMANT <u>Robert Neill, Kansas City, 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>Hemorrhage Basilar Artery</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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	
19. WAS AUTOPSY PERFORMED? YES <input 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 _____ 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>1957</u> to <u>Sept 26, 60</u> and last saw her <u>him</u> alive on <u>Sept 26, 60</u> Death occurred at <u>6:45 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Harold W. Vore, M.D.</u>				22b. ADDRESS <u>201 Plaza Mad Bldg. K.C. Mo.</u>		22c. DATE SIGNED <u>Sept 28, 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-28-60</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Lawrence, Kansas</u>	
24. FUNERAL DIRECTOR <u>Warren Funeral Home, Lawrence, Kans.</u>				25. DATE RECD. BY LOCAL REG. <u>9-28-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L-Dwyer</u>	

DOCUMENT

HELDOLD W. VORE, M.D. 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

John R. [Signature]
Licensed Embalmer No. 45
P. O. Address Kenia

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.