

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

**-60-035080**

**FILED VS SEP 8 6 1960**

**149**

Primary Registration District No. **1002**

Registrar's No. **4641**

STATE FILE NUMBER

|  |  |  |  |   |   |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>JACKSON</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>                                       |   |  |   |   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>  |  | Length of stay in 1b<br><b>2 YEARS</b>   |  | c. CITY OR TOWN <b>KANSAS CITY</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |   |  |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>3621 WARWICK BLVD.<br/>                 LINDEMAN-McCARTY, INC.</b>   |  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>6620 TRUMAN ROAD</b>                                    |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Mayme</b> Middle <b>Thornton</b> Last <b>Thornton</b>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>1960</b>   |   |  |   |   |  |   |  |
| <b>5. SEX</b><br><b>FEMALE</b>   |  | <b>6. COLOR OR RACE</b><br><b>WHITE</b>  |  | <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/><br><b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b><br><b>FEB. 28, 1887</b>                                      |   | <b>9. AGE</b> (last birthday) <b>73</b><br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HR: Hours _____ Min. _____ |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>AT HOME</b>   |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>-----                                    |   | <b>11. BIRTHPLACE</b> (City and state or country)<br><b>CASS COUNTY, MISSOURI</b>                           |  | <b>12. CITIZEN OF WHAT COUNTRY</b><br><b>U. S. A.</b>   |   |  |   |  |
| <b>13a. FATHER'S NAME</b><br><b>DR. GEORGE FARROW</b>  |  |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><b>MARY THORPE</b>                               |   |   | <b>14. NAME OF HUSBAND OR WIFE</b><br><b>UNKNOWN THORNTON</b>                        |   |   |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>NONE</b>  |   | <b>17. INFORMANT</b> Address <b>1000 POWER &amp; L<br/>                 CORNELIUS ROACH, III. K. C. MO.</b> |  |   |   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome</b><br>DUE TO (b) <b>Arteriosclerosis + Cerebral</b><br>DUE TO (c) <b>sclerosis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>several years</b>  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Psychosis and Dementia.</b>  |  |  |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | <b>20a. ACCIDENT SUICIDE HOMICIDE</b><br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>      |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)<br><b>None</b>  |   |  |   |   |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Hour _____ s.m. _____ p.m. _____<br>Month, Day, Year<br><b>None</b>  |  | <b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>  |   | <b>20f. CITY, TOWN, OR LOCATION</b><br><b>None</b>                                   |   | COUNTY _____ STATE _____  |  |   |  |
| <b>21. I attended the deceased from</b> <b>Feb 6 1958</b> to <b>9-17-58</b> and last saw her alive on <b>9-17-59</b><br>Death occurred at <b>Above nursing home</b> on the date stated above, and to the best of my knowledge, from the causes stated.<br>at <b>6:50 P.M.</b>  |  |  |  | <b>22a. SIGNATURE</b> (Degree or title)<br><b>Harvey Jennett, M.D.</b>  |   |  |   | <b>22b. ADDRESS</b><br><b>1500 Professional Bldg<br/>                 Kansas City, Mo.</b>                                    |  | <b>22c. DATE SIGNED</b><br><b>9-8-60.</b> |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>BURIAL</b>  |  | <b>23b. DATE</b><br><b>SEPT. 10, 1960</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORIUM</b><br><b>WASHINGTON CEMETERY</b>   |   | <b>23d. LOCATION</b> (City, town, or county) (State)<br><b>KANSAS CITY MISSOURI</b>  |   |   |  |   |  |
| <b>24. FUNERAL DIRECTOR</b><br><b>D. W. NEWCOMER'S SONS KANSAS CITY, MO.</b>   |  |  |  | <b>25. DATE RECD. BY LOCAL REG.</b><br><b>9-10-60</b>   |   | <b>26. REGISTRAR'S SIGNATURE</b><br><b>H. L. Dwyer.</b>                              |   |   |  |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Harvey Jennett

**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

*Chester K. Brown*

Licensed Embalmer No. 4931

P. O. Address 100 W. 11th St.

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