

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

-60-035083

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4692 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 3 MONTHS	c. CITY OR TOWN PRAIRIE VILLAGE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7718 ABERDEEN ROAD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last TIGNER	4. DATE OF DEATH Month SEPTEMBER Day 13 Year 1960
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAR. 22, 1980	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PATTERSON FALLS, PA.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME TIGNER	14. NAME OF HUSBAND OR WIFE WILHELMINA TIGNER
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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. 505-03-4316-A	17. INFORMANT LOUIS L. TIGNER Address 7718 ABERDEEN ROAD PRAIRIE VILLAGE, KANSAS
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease	INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____
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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
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21. I attended the deceased from **Jan 1960** to **Sept 13, 60** and last saw ^{him} alive on **Sept 13, 60**
Death occurred at **9:20 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Harold W. Voth, M.D.	22b. ADDRESS 201 Plaza Med Bldg. Kansas City, Mo	22c. DATE SIGNED Sept 14, 60
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE SEPT. 15, 1960	23c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS	23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS ADDRESS 1351 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 9-14-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Harold W. Voth**

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 Marion A. Preston

Licensed Embalmer No. 5040

P. O. Address H. C. 70

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.