

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. SEP 26 1960

149

1002

4621

-60-035094

STATE FILE NUMBER

INDEXED

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

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 38 yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bra-Ton Nursing Home			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1431 West 50th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE EMILY VEGIARD				4. DATE OF DEATH Month 9 Day 5 Year 1960				
5. SEX Female	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 9/22/1873	9. AGE (last birthday) 86	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) GLENBURN PA.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Wm. C. Northup			13b. MOTHER'S MAIDEN NAME ANNE ATHERTON			14. NAME OF HUSBAND OR WIFE CHARLES E. VEGIARD		
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. none		17. INFORMANT Address Dr. E.N. VEGIARD, 4304 WALNUT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, hypostatic one day.							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebro-vascular accident Sept 7/1960						
		DUE TO (c) Hypertension Cerebro-vascular disease. Many years						
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 checked="" type="checkbox"/>	20a. ACCIDENT no	SUICIDE no	HOMICIDE <input type="checkbox"/> no	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 many years ago to Sept 5/1960 and last saw her alive on _____ Death occurred at Bra-Ton Nursing Home on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Terry E. Lilly MD. (Degree or title)				22b. ADDRESS 915 Argyle Bldg. K.C. Mo.			22c. DATE SIGNED 9/6/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-9-60	23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS		23d. LOCATION (City, town, or county) KANSAS CITY, MISSOURI (State)			
24. FUNERAL DIRECTOR FLORAL HILLS MEMORIAL CHAPELS ADDRESS K.C. MO.			25. DATE RECD. BY LOCAL REG. 9-9-60		26. REGISTRAR'S SIGNATURE H-L-O waffer			

DOCUMENT

Terry E. Lilly 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 Forrest D. Caldwell

Licensed Embalmer No. 4714

P. O. Address K.C. MO.

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.