

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 14 1960

149

Registration District No. Primary Registration District No. 1002

Registrar's No.

4901 -60-035107  
STATE FILE NUMBER

NDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Jackson		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Missouri		b. COUNTY Jackson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in 1b 2 1/2 Yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 5504 Olive Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First BERTHA		Middle LEONA		Last WELLS		Month Day Year September 27th, 1960	
5. SEX Female	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 4-1-1881	9. AGE (last birthday) 79	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		11. BIRTHPLACE (City and state or country) Platte Co. Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Coleman Laurance			13b. MOTHER'S MAIDEN NAME Laura Wilson			14. NAME OF HUSBAND OR WIFE James E. Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address James E. Wells, 5504 Olive St. K.C. Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) A. H. C. U. D.						YEARS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CORONARY OCCLUSION						SUDDEN	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 ONE YEAR to and last saw her alive on 9-27-60 Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) H. L. Dwyer M.D.				22b. ADDRESS 6749 Maple K.C. MO		22c. DATE SIGNED 9-28-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-28-1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri		
24. FUNERAL DIRECTOR Freeman Mortuary, Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 9-28-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Quistgard

**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 Walter H. Erue

Licensed Embalmer No. 435

P. O. Address Kansas

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.