

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 24 1960

-60-037519

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in 1b 4 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 State Hospital No. 2		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 448 Booth
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Agnes Middle Marie Last Flournoy			4. DATE OF DEATH Month October Day 16 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 2/4/1900	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Kansas City Missouri	12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME Jeremiah T. Haley		13b. MOTHER'S MAIDEN NAME Johanna Jennings		14. NAME OF HUSBAND OR WIFE Unknown		

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 State Hospital No. 2 Records, St. Joseph Mo.	Address _____
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Coronary Thrombosis		
DUE TO (b) Arteriosclerotic Heart disease		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. C.B.S. associated with chronic brain disease		
DUE TO (c) with cerebral arteriosclerosis		

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
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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.)
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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
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21. I attended the deceased from 10/16/60 to 10/16/60 and last saw her alive on 10/16/60
Death occurred at 10:00P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Mohammed Taha M.D.	22b. ADDRESS State Hospital #2, St. Joseph, Mo.	22c. DATE SIGNED 10/17/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/17/60	23c. NAME OF CEMETERY OR CREMATORY Kansas City Missouri	23d. LOCATION (City, town, or county) (State)
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FUNERAL DIRECTOR Sheil Colonial Funeral Home Kansas City, Mo.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. Oct. 21, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Standell
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Tahir, M.D.

OCT 24 1960

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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