

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 27 1960

5064-60-038338

5064

STATE FILE NUMBER

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5220 Wilburn Court</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MRS. LENA</u> Middle <u>M.</u> Last <u>DONAHUE</u>			<b>4. DATE OF DEATH</b> Month <u>Oct.</u> Day <u>7,</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-24-73</u>	<b>9. AGE (last birthday)</b> <u>87</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Clay County, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13a. FATHER'S NAME</b> <u>Samuel Jackson</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Missouri Ann Foster</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>William J. Donahue</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Mrs. Paul B. Dessent- 5220 Wilburn St.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Intracerebral hemorrhage</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u> <u>23 days</u> <u>unknown</u>		
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. p.m.							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>5/27/60</u> to <u>10/7/60</u> and last saw <sup>her</sup> alive on <u>10/6/60</u> Death occurred at <u>St. Joseph Hospital</u> <u>6:15 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>J. E. Van Buskirk, M.D.</u>			<b>22b. ADDRESS</b> <u>5246 St. John K C Mo</u>		<b>22c. DATE SIGNED</b> <u>10/7/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>10-10-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Missouri</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Melody-MoGilley-Eylar-1800 E. Linwood</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-8-60</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>H. L. Sawyer</u>			

DOCUMENT

BY AFFIDAVIT OF J. VAN BUSKIRK MEDICAL CERTIFICATION

1202

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Dr. Jerry U  
5246 St. G  
BE 1-0141

7m. until 4:30

**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 James E. Hackle

Licensed Embalmer No. 4573

P. O. Address K.C. MO

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.