

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038456

FILED VS OCT 27 1960

149

1002

5004

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>40 yrs. inh.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>4529 Cleveland</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>G.</b> Last <b>Mc Clellan</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>5,</b> Year <b>1960</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-71</b>
9. AGE (last birthday) <b>89</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Havensville, Kansas</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>John Woodyard</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Woodyard</b>		14. NAME OF HUSBAND OR WIFE <b>Daniel B. Mc Clellan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Ellen Schaeffer Kansas City, Kans.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic &amp; hypertensive cardiovascular disease</b>			<b>10 yrs. -#</b>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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 <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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>1950</b> , to <b>10-5-60</b> and last saw her/him alive on <b>10-4-60</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Mary C. Colglazier, M.D.</b>		22b. ADDRESS <b>3317 E. 43rd.</b>	22c. DATE SIGNED <b>10-5-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10-7-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kans.</b>
24. FUNERAL DIRECTOR <b>R. A. Fulton</b>	ADDRESS <b>Kansas City, Kans.</b>	25. DATE RECD. BY LOCAL REG. <b>10-5-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Mary C. Colglazier**

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.