

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. NOV 9 1960 149

60-038547  
5386 STATE FILE NUMBER

Registration District No. Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY <i>Jackson</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Length of stay in 1b <i>20 yrs</i>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Heartstone Nursing Home</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS <i>1310 Askew</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>OLIVE</i> Middle <i>D</i> Last <i>SEEVER</i>			4. DATE OF DEATH Month <i>10</i> Day <i>25</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>6/22/1872</i>	9. AGE (last birthday) <i>88</i> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. BIRTHPLACE (City and state or country) <i>Peoria, Illinois</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Andrew King</i>		13b. MOTHER'S MAIDEN NAME <i>Abbie Fry</i>		14. NAME OF HUSBAND OR WIFE <i>James Seever</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Mrs Olive Elloitt 8802 E. 8th K.C. MO</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma of Face</i> DUE TO (c) <i>Arteriosclerotic</i> 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					INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i> <i>4 years</i> <i>10 years</i>	
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 Month, Day, Year a.m. p.m.	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 <i>9-24-60</i> to <i>10-25-60</i> and last saw her/him alive on <i>10-25-60</i> Death occurred at <i>3:40 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Frank Paul Laurence</i> (Degree or title)			22b. ADDRESS <i>428 S. White Ave</i>		22c. DATE SIGNED <i>10-25-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>10/27/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Nortonville Cemetery</i>	23d. LOCATION (City, town, or county) <i>Nortonville, Kansas</i>			
24. FUNERAL DIRECTOR <i>Floral Hills Memorial Chapels Inc</i>		ADDRESS <i>K.C. Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>10-26-60</i>	26. REGISTRAR'S SIGNATURE <i>H-L. Dwyer</i>		

DOCUMENT

BY AFFIDAVIT OF Frank Paul Laurence, M.D. MEDICAL CERTIFICATION

**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 Ernest D. Goldsno

Licensed Embalmer No. 4719

P. O. Address K. P. V.

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.