

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041338

FILED VS NOV 28 1960

Registration District No. 5-9 Primary Registration District No. \_\_\_\_\_ Registrar's No. 192 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>WYANDOTTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AUSTIN Township</u>		Length of stay in 1b _____	c. CITY OR TOWN <u>KANSAS City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 miles S. HARRISONVILLE, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>58 South 18th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>South Jr.</u>			4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-43</u>	9. AGE (last birthday) <u>16</u>	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) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>James Thomas South Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA E. FOGLESONG</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs MARTHA E. South 58 S. 18th K.C. KANSAS</u>	
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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: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (traumatic)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____		
	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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto wreck</u>			
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20c. TIME OF INJURY Hour <u>1:55</u> a.m. <u>pm</u> Month, Day, Year <u>Nov 13 60</u>					
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION COUNTY <u>Austin</u> STATE <u>Cass Township</u> <u>U.S. 71 South of Harrisonville Mo 7 miles SW.</u>			
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at Libon on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert C. Phillips D.C. Coroner Cass County</u>		22b. ADDRESS <u>Harrisonville MO.</u>		22c. DATE SIGNED <u>11/13/60</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY KANSAS</u>		
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24. FUNERAL DIRECTOR ADDRESS <u>ATKINSON-Dickey HARRISONVILLE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>11-13-60</u>	26. REGISTRAR'S SIGNATURE <u>Harold W. M.D.</u>		
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

0351 68 10N

**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 Robert Johnson

Licensed Embalmer No. 4902

P. O. Address Hammond

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