

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

5500-60-041859

FILED VS NOV 23 1960

149

1002

5500

STATE FILE NUMBER

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>19 yrs</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>QUEEN OF THE WORLD</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2718 BENTON</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEE ETHEL BATES</b>				4. DATE OF DEATH Month Day Year <b>10-30-60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-1911</b>	9. AGE (last birthday) <b>48 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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>George Town, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Lee Randolph</b>			13b. MOTHER'S MAIDEN NAME <b>Annabelle Bailey</b>			14. NAME OF HUSBAND OR WIFE <b>William Bates</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>-</b>		17. INFORMANT Address <b>William Bates 2718 Benton</b>		
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>MASSIVE PONTINE-CEREBELLAR HEMORRHAGE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS.</b>
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 checked="" 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 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
21. I attended the deceased from <b>10/29/60</b> to <b>10/29/60</b> and last saw her/him alive on <b>10/29/60</b> Death occurred at <b>8:10 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) <b>Arthur M. Brady M.D.</b>			22b. ADDRESS <b>3039 Brooklyn</b>			22c. DATE SIGNED <b>11/1/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-3-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>			
24. FUNERAL DIRECTOR <b>WATKINS BROS. FUNERAL HOME 18th &amp; Benton</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>11-2-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Sawyer</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Arthur M. Brady

STATE OF OHIO  
DEPARTMENT OF HEALTH  
DIVISION OF BUREAU OF HEALTH

STATE OF OHIO  
DEPARTMENT OF HEALTH  
DIVISION OF BUREAU OF HEALTH

00-00-01

STATE

DEPT

HEALTH

CHIEF

EMBALMER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bruce P. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Bent

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.