

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

579760-041906
5797 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 50 yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 3630 Jefferson (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) ISOBEL BUSBEY			4. DATE OF DEATH Month 11 Day 17 Year 60				
First	Middle		Last	Month	Day		Year

5. SEX Fe	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-3-92	9. AGE (last birthday) 68	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) Secretary	10b. KIND OF BUSINESS OR INDUSTRY R.R.	11. BIRTHPLACE (City and state or country) Minden, Louisiana	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME No Record	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE XX
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 702-12-1277	17. INFORMANT Inez Skeffington, 3630 Jefferson
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - left Hemisphere		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
DUE TO (b) Generalized Arteriosclerosis -		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis obliterans left lower extremity; coronary arteriosclerosis & failure		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <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.) Coronary artery failure
---	---	--

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 Minden, Louisiana	COUNTY _____ STATE _____
---	--	--	--	--------------------------

21. I attended the deceased from June 57 to date 4-17-60 and last saw her alive on 11-17-60 Death occurred at 10:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) Carl D. Emma M.D.	22b. ADDRESS Argyle Bldg - K.C. Mo	22c. DATE SIGNED 11-17-60
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-19-60	23c. NAME OF CEMETERY OR CREMATORY Minden Cemetery	23d. LOCATION (City, town, or county) (State) Minden, Louisiana
---	------------------------------	--	---

24. FUNERAL DIRECTOR Wagner Funeral Home, K.C. Mo.	25. DATE RECD. BY LOCAL REG. 11-18-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
--	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Carl D. Emma

DEC 20 1960

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 Alvin R. Haunscheld

Licensed Embalmer No. 4159

P. O. Address H.C. M

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