

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1960

5537-60-041949

5587

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 Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 59 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 Little Sisters of Poor 5331 Highland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5331 Highland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Jean F. Cushing	4. DATE OF DEATH November 2 1960
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Abilene, Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Patrick J. Byrne	13b. MOTHER'S MAIDEN NAME Winifred Ryan	14. NAME OF HUSBAND OR WIFE Michael J. Cushing
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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) No	16. SOCIAL SECURITY NO. 486- 26-3626	17. INFORMANT Address Michael P Cushing, 4122 Charlotte, K.C Mo
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral thrombosis		2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) cerebral arterio sclerosis	20 years
	DUE TO (c) A	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) malnutrition	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from Nov 1, 1960 to Nov 1, 1960 and last saw her ^{her} ~~him~~ alive on Nov 1, 1960
Death occurred at 1:25 PM Nov 2, 1960 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Warren F. Wilhelm M.D.	22b. ADDRESS Prof. Bldg. Kansas City, Mo	22c. DATE SIGNED 11/3/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-5-1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or County) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar, 20 West Linwood K C. Mo	25. DATE RECD. BY LOCAL REG. 11-3-60	26. REGISTRAR'S SIGNATURE H. L. Dwyer
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF
Warren F. Wilhelm
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 by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm. H. Shultz

Licensed Embalmer No. 5030

P. O. Address A.C. 116

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.