

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

-60-042112

5721

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 b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 67 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 Doctor's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1635 West 51st St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Fannie Middle Norton Last Lewis				4. DATE OF DEATH Month Nov. Day 13 Year 1960									
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 May 2, 1881		9. AGE (last birthday) 79		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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (City and state or country) Atchinson, Kansas			12. CITIZEN OF WHAT COUNTRY U. S. A.				
13a. FATHER'S NAME Calvin B. Norton				13b. MOTHER'S MAIDEN NAME Louisa Jane Castle				14. NAME OF HUSBAND OR WIFE Ward Moffitt Lewis					
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. None		17. INFORMANT Mary Lewis, 1635 W. 51st K. C. Mo Address							
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 about 18 hours Conditions, if any, which gave rise to above cause (e), stating the underlying cause last. DUE TO (b) Hypostatic Pneumonia about 24 hrs DUE TO (c) Arteriosclerosis - Senility about 10 yrs.										INTERVAL BETWEEN ONSET AND DEATH			
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			
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 April 4-1966 to Nov. 13/1960 and last saw her/him alive on Nov. 12-1960 Death occurred at 12:42 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) A. B. Boyer DD						22b. ADDRESS 5529 Troost KCMo				22c. DATE SIGNED 11/14/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 11-15-60		23c. NAME OF CEMETERY OR CREMATORY Mount Washington			23d. LOCATION (City, town, or county) (State) Kansas City, Missouri					
24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo.					25. DATE RECD. BY LOCAL REG. 11-14-60			26. REGISTRAR'S SIGNATURE H-L. Dwyer					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

A. B. Boyer

11. A 2m

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 J. S. Walton

Licensed Embalmer No. 2744

P. O. Address K. C. MO

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