

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

5697 -60-042139
5697 STATE FILE NUMBER

FILED VS DEC 5 1960 149

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

DED

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 lb. 35 YEARS		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 4005 ST. JOHN			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4005 ST. JOHN		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES E. WAGNER				4. DATE OF DEATH Month Day Year NOVEMBER 10 1960				
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH AUG 18 1900	9. AGE (last birthday) 60	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 DOMESTIC		11. BIRTHPLACE (City and state or country) LEXINGTON, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME RUSSELL WOODRUFF			13b. MOTHER'S MAIDEN NAME CATHERINE		14. NAME OF HUSBAND OR WIFE HUBERT J. MAGNER			
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 HUBERT J. MAGNER Address 4005 ST. JOHN.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma, abdomen						INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of Colon.						2 yrs.		
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			
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 Month, Day, Year a.m. p.m.								
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 8/31/59 to 11/10/60 and last saw her live on 11/10/60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE E. A. Wilkinson M.D. (Degree or title)				22b. ADDRESS 1332 Professional Bldg		22c. DATE SIGNED 11/11/60 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11-12-60	23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City Mo.			
24. FUNERAL DIRECTOR MUENLEBACH ADDRESS 6800 Troost		25. DATE RECD. BY LOCAL REG. 11-11-60		26. REGISTRAR'S SIGNATURE H. L. Dreyer				

DOCUMENT

MEDICAL CERTIFICATION

WILKINSON

BY AFFIDAVIT OF

R. WILKINSON
PROFESSIONAL BODG
BAI-1040
2:30 - 4:45

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 Clavel Can Jr.

Licensed Embalmer No. 21934

P. O. Address K.C. 14, Mo

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.