

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042200

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149

Primary Registration District No. 1002

Registrar's No. 5409

STATE FILE NUMBER

NDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Geo. C. Kealhofer

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansad City, Mo.</b>		Length of stay in 1b <b>2 hrs.</b>	c. CITY OR TOWN <b>Jackson County</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1224 Admiral</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>R.R. #2 Old Lexington Highway and Little Blue</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MRS. DOROTHY LENORA PAXTON</b>			4. DATE OF DEATH Month <b>October</b> Day <b>26</b> , Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</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>Feb. 22, 1913</b>
9. AGE (last birthday) <b>47</b>		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) <b>Spray painter--Hazzelle's Marionettes</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ripley Station Mo</b>	11. BIRTHPLACE (City and state or country) <b>USA</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Albert S. Anthony</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Allison</b>
14. NAME OF HUSBAND OR WIFE <b>Claude Paxton</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>492-18-7996</b>
17. INFORMANT <b>Mr. Claude Paxton</b>		Address <b>R.R. #2, Jackson Co., Mo.</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>Distal aneurysm of circle of Willis</b>			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)	
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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Geo. C. Kealhofer</b>		22b. ADDRESS <b>6627 Prater St, Ind.</b>	22c. DATE SIGNED <b>11-26-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 28, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Salem Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>24 Highway East of Indep.</b>
24. FUNERAL DIRECTOR ADDRESS <b>OTT &amp; MITCHELL, Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-27-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>

**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 Henry S. Mitchell

Licensed Embalmer No. 392

P. O. Address Indep.

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