

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS NOV 17 1960**

**54-360-042209**

**5423**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b- <u>8 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3027 Troost Avenue</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1010 Bellefontaine</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>WILLIAM FLOYD PICKERING</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>October 28 1960</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/29/1901</u>		<b>9. AGE (last birthday)</b> <u>59</u>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HR</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer &amp; Handy Man</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Apartments Bldgs</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>Vernon, Kansas</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>			
<b>13a. FATHER'S NAME</b> <u>David Pickering</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Jennie Almond</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Cleo Pickering</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>702-18-4623</u>				<b>17. INFORMANT</b> Address <u>1010 Bellefontaine</u> <u>William Pickering, Bellefontaine</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> 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										INTERVAL BETWEEN ONSET AND DEATH					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>										<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <u>8:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
<b>22a. SIGNATURE</b> (Degree or title) <u>W. C. Kealhofer, M.D., County Coroner</u>						<b>22b. ADDRESS</b> <u>6627 Prospect St. Overland Park, Mo.</u>						<b>22c. DATE SIGNED</b> <u>10-28-60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE</b> <u>Oct. 29, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Neosho Falls Cemetery</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>Neosho Falls Kansas</u>							
<b>24. FUNERAL DIRECTOR</b> <u>D.W. Newcomer's Sons, Kansas City, Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-28-60</u>				<b>26. REGISTRAR'S SIGNATURE</b> <u>W. C. Kealhofer</u>							

DOCUMENT

BY AFFIDAVIT OF C. Kealhofer 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 Louisa Quest

Licensed Embalmer No. 4096

P. O. Address N.C. Mo.

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