

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042348

FILED VS. DEC 12 1960

149

Primary Registration District No. 1002 Registrar's No. 5880

STATE FILE NUMBER

INDEXED

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 56 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 Lewellyn N. H			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3001 Main		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LEW. Middle W Last WITT				4. DATE OF DEATH Month 11 Day 19 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11 30 75	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer			10b. KIND OF BUSINESS OR INDUSTRY R. R.		11. BIRTHPLACE (City and state or country) Manhattan, Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A		
13a. FATHER'S NAME Simpson Witt			13b. MOTHER'S MAIDEN NAME Mary McCormack			14. NAME OF HUSBAND OR WIFE _____			
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 36 8359		17. INFORMANT Address Mrs. Willma Allin 4917 So. Benton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION							INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Myocarditis							6 years		
DUE TO (c) Arteriosclerosis							10 years		
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 checked="" 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 1-1-60 to 11-19-60 and last saw her/him alive on 11-19-60 Death occurred at 4:23 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Paul Laurence Medical Certification				22b. ADDRESS 428 So. White Ave			22c. DATE SIGNED 11-19-60		
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11 22 1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) Kansas City Missouri		(State)		
24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels, Inc			K.C. MO	25. DATE RECD. BY LOCAL REG. 11-22-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer			

DOCUMENT

BY AFFIDAVIT OF Paul Laurence 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ernest D. Caldwell

Licensed Embalmer No. 471

P. O. Address H. R. W.

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.