

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042390

FILED VS NOV 22 1964 46

3026

537

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY JACKSON COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LA FAYETTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE	Length of stay in 1b 2 WEEKS	c. CITY OR TOWN LEXINGTON	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION INDEPENDENCE SANITARIUM	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1018 BLOOM	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last KATHLEEN B. MAIB			4. DATE OF DEATH Month Day Year 11 11 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-5-03	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) LEXINGTON Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME PATRICK MORRIS		13b. MOTHER'S MAIDEN NAME ANNA BOYLES		14. NAME OF HUSBAND OR WIFE CLARENCE MAIB		
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 Address CLARENCE MAIB LEXINGTON MO.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas		INTERVAL BETWEEN ONSET AND DEATH 6 weeks.
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 checked="" 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 **11-1-60** to **11-11-60** and last saw her ^{him} alive on **11-11-60**
Death occurred at **3:00 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert H. Walker MD		22b. ADDRESS 10901 W. Union Rd. Independence, Mo.		22c. DATE SIGNED 11-14-60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-14-60	23c. NAME OF CEMETERY OR CREMATORY CALVARY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) LEXINGTON MISSOURI	
24. FUNERAL DIRECTOR ADDRESS VAUGHN - WALKER LEXINGTON MO.		25. DATE RECD. BY LOCAL REG. 11-14-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 23 1981

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 W.B. Vaughn

Licensed Embalmer No. 4023

P. O. Address Lexington

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.