RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1961 149

-60-046024
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6449

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in Jb: 20 years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 210 E. 33rd St. — Inside Limits Yes ☒ No ☐	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐ d. STREET ADDRESS (If outside, give location) 210 E. 33rd St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle A Last DOYLE

4. DATE OF DEATH: Month Dec. Day 22 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Mar 7, 92

9. AGE (last birthday): 68 — 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): Dental Hygenist

10b. KIND OF BUSINESS OR INDUSTRY: Burghettson

11. BIRTHPLACE (City and state or country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Ira Doyle

13b. MOTHER'S MAIDEN NAME: Iona Wiley

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Address: Mrs. P. Brod, 210 E. 33rd, K.C., 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) Amyotrophic Lateral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cause Unknown

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION Kansas City COUNTY Jackson STATE Mo

21. I attended the deceased from October, 1959 to Dec 22, 1960 and last saw her/him alive on Dec 8th, 1960

Death occurred at 7:30 A.M. Dec 22, 1960 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Joseph Getelson M.D.

22b. ADDRESS: 900 Rialto Bldg.

22c. DATE SIGNED: 12-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Dec. 24, 60

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): Kansas City, Mo.

24. FUNERAL DIRECTOR: P.B. Lapetina Fun'l Home, K.C., Mo. ADDRESS

25. DATE RECD. BY LOCAL REG.: 12-23-60

26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Joseph Getelson DOCUMENT 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

~~Student~~ _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jack T. Moore

Licensed Embalmer No. 4729

P. O. Address Kansas Ci

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