

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960 149

5989 -60-046100
5989 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 5 MINUTES	c. CITY OR TOWN INDEPENDENCE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION General Osteo. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 13000 East 49th. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BURL DANIEL HAMILTON			4. DATE OF DEATH Month Day Year November 27, 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 type="checkbox"/> Married	8. DATE OF BIRTH 10-11-1910	9. AGE (last birthday) 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY HOFFMAN BUICK CO. Automotive	11. BIRTHPLACE (City and state or country) Seward, Kansas.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John E. Hamilton		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Dorothy Hamilton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 487-03-4442	17. INFORMANT Address Mrs. Dorothy Hamilton, 13000 E. 49th. Independence, Missouri	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Artery Occlusion DUE TO (c) Myocardial Fibrosis			INTERVAL BETWEEN ONSET AND DEATH minutes 1/2 month months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Adhesive Pericarditis		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 Month, Day, Year a.m. p.m.	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 **Aug 1, 1960** to **Nov 27 1960** and last saw him alive on **Nov 26, 1960**
Death occurred at **11:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Verne J. James MD		22b. ADDRESS 926 E. 11th St.		22c. DATE SIGNED 11-29-60
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE NOV. 30, 1960	23c. NAME OF CEMETERY OR REPOSITORY FOREST HILL CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 11-29-60	26. REGISTRAR'S SIGNATURE H-L. Dwyer	

DOCUMENT BY AFFIDAVIT OF Verne J. James, M.D. 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 James W. Stegner

Licensed Embalmer No. 378

P. O. Address H. C. 71

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.