

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046145

FILED VS. DEC 30 1960

149

Primary Registration District No. 10-02 Registrar's No.

6266

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in lb <b>50 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>3511 Locust Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AMEILA JOHNSON</b>				4. DATE OF DEATH <b>December 6 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4/5/1865</b>	
9. AGE (last birthday) <b>95</b>		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) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (City and state or country) <b>Detroit, Michigan</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>unknown</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Irene Coolege, Estes Park, Colorado</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b>						<b>5 years</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>						<b>10 years</b>	
DUE TO (c) <b>857</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>gangrene right foot</b>						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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>12/31/1955</b> to <b>12/5/60</b> and last saw her alive on <b>NOV 19-1960</b> Death occurred at <b>4:45 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>H. E. Smith M.D.</b> (Degree or title)				22b. ADDRESS <b>411 N. 2nd St. P.O. Box 100</b>		22c. DATE SIGNED <b>12/6/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>FOREST HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons, Kansas City, Missouri</b> ADDRESS <b>Creek Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>12-13-60</b>		26. REGISTRAR'S SIGNATURE <b>H-L-Dwyer</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. E. Smith

**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 Chester K. Brown

Licensed Embalmer No. 495

P. O. Address K. O. W.

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.