

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 1 9 1960

-60-046162

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6008 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>2 yrs</u>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gen Hosp' D.O.A.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1014 E 9th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DEBRA</u> Middle <u>SUE</u> Last <u>KING</u>			4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>60</u>			
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5. SEX <u>F</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-58</u>	9. AGE (last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FRANK KING</u>	13b. MOTHER'S MAIDEN NAME <u>BETTY FRANCES GREEN</u>	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT <u>Frank King</u> Address <u>1014 E. 9th</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute meningitis</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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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
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> / <u> </u> / <u> </u>

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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Clayton A. Owens Coroner</u> (Degree or title)	22b. ADDRESS <u>152 Mission Station</u>	22c. DATE SIGNED <u>11-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURNED</u>	23b. DATE <u>11/29/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ST. MARY'S CEM.</u>
23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO.</u>	23e. (State)	24. FUNERAL DIRECTOR <u>PETER B. Laperina</u> ADDRESS <u>Fun Home, KC Mo.</u>
25. DATE RECD. BY LOCAL REG. <u>11-30-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>	

DOCUMENT

BY AFFIDAVIT OF

Hugh H. O'neill, 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 Forrest D. Colman

Licensed Embalmer No. 4714

P. O. Address K.C. Mo

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.