

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 19 1960

599650-046347
 5996 STATE FILE NUMBER

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

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lackaon</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lackaon</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | | Length of residence <u>13 yrs</u> | | c. CITY OR TOWN <u>Raytown</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lake Side Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>9110 E. 65th Terrace</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>B.</u> Last <u>Slater</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>60</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan 28 1922</u> | | | |
| 9. AGE (last birthday) <u>68</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u> | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Brown</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lucinda</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Stephen N. Slater</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>494-20-8047</u> | | 17. INFORMANT <u>M. Stephen N. Slater 5110 E 65th</u> | | | Address <u>Raytown Mo</u> | |
| 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) <u>Uremia</u> | | | | | | | <u>8 days</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardio-renal syndrome</u> | | | | | | | <u>years</u> | | |
| DUE TO (c) <u>Generalized Atherosclerosis</u> | | | | | | | <u>years</u> | | |
| 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 | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | | 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 <u>11/1/60</u> to <u>11-28/60</u> and last saw her alive on <u>11-28-60</u> Death occurred at <u>8:55/P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>M.R. Lippman D.O.</u> | | | | 22b. ADDRESS <u>9140 E. 50th Hwy K.C. 33, Mo</u> | | | 22c. DATE SIGNED <u>11/28/60</u> | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>12-1 60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u> | | | |
| 24. FUNERAL DIRECTOR <u>Floral Hills Memorial Chapels Inc</u> | | | | ADDRESS <u>K.C. Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>11-29-60</u> | | 26. REGISTRAR'S SIGNATURE <u>H.L. Dwyer</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. R. Lippman

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.