

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046356

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Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 5978 STATE FILE NUMBER

DED

1/5/60

AT BURY

anterior cerebral artery

Pt. II Occlusion rt. anterior cerebral artery  
BY AFFIDAVIT OF attending physician  
Warren F. Wilhelm M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Wade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>3 yrs.</u>		c. CITY OR TOWN <u>Lockwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Greta</u> Middle <u>Lamay</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1896</u>		9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Wade Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Maurice Miller</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Glenn</u>			14. NAME OF HUSBAND OR WIFE <u>Herbert Smith</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>none</u>		17. INFORMANT <u>Gerald Smith Grandview Mo.</u>			Address	
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>occlusion anterior cerebral artery rt.</u> DUE TO (b) <u>Primary brain tumor, Malignant</u> DUE TO (c) <u>infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Occlusion rt. anterior cerebral artery</u>						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 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.)					
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 <u>Nov 7, 1960</u> to <u>Nov 28, 1960</u> and last saw her alive on <u>11/27/1960</u> Death occurred at <u>9:05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deceased or title) <u>Warren F. Wilhelm, M.D.</u>				22b. ADDRESS <u>Prof. Bldg. Kansas City Mo</u>				22c. DATE SIGNED <u>11/28/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lockwood Mo</u>		23d. LOCATION (City, town, or county) <u>Lockwood Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Albion Mortuary, Lockwood, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-28-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u>			

**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 John R. Dick  
Licensed Embalmer No. 45  
P. O. Address Kansas

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