

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046374

FILED VS DEC 19 1960

6051

STATE FILE NUMBER

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

UNDECEASED

| | | | | | | | | |
|---|---------------------------|---|--|--|---|--|---|--|
| 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 1b <u>7 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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>200 W. Armour</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Sullens</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>1</u> Year <u>1960</u> | | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>9-25-1910</u> | 9. AGE (last birthday) <u>50</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>Chef</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | | 11. BIRTHPLACE (City and state or country) <u>Clarksburg Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>E. Sullens</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Rebecca Ruth Sullens</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Ruth Sullens</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u> | | | 16. SOCIAL SECURITY NO. <u>524-10-9863</u> | | 17. INFORMANT <u>Ruth Sullens</u> Address <u>200 W Armour K.C. Mo</u> | | | |
| 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>Metastatic Bronchogenic Carcinoma Lung</u> DUE TO (b) <u>Grade III squamous cell</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 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 <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 checked="" 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>10-11-60</u> to <u>12-1-60</u> and last saw her/him alive on <u>12-1-60</u> Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>J. Montgomery M.D.</u> | | | | 22b. ADDRESS <u>1837 Profess Rd. K.C. Mo</u> | | 22c. DATE SIGNED <u>12/2/60</u> | | |
| 23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Removal</u> | | 23b. DATE <u>12-2-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Clarksburg Mo.</u> | | State <u> </u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Robert R. Speake Indep. Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>12 2 60</u> | | 26. REGISTRAR'S SIGNATURE <u>H-L-Dwyer</u> | | | |

DOCUMENT

G. MONTGOMERY M.D.

BY AFFIDAVIT OF

MS DEC 19 1960

DEC 20 1960

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

Wayne Smith

Licensed Embalmer No. 5081

P. O. Address London, Mo

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