

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 28 1966 *46*

**-60-046462**

Registration District No. *46* Primary Registration District No. *3026* Registrar's No. *609* STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Jackson</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>15 Mo</b>		c. CITY OR TOWN <b>Blue Springs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>pines Rst Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>105 S 7th</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Matilda</b> Middle <b>May</b> Last <b>Duncan</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Fm</b>	6. COLOR OR RACE <b>Wh</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>Dec 3 1874 -86</b>		9. AGE (last birthday) <b>86</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>		11. BIRTHPLACE (City and state or country) <b>Shakelford Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Bybee Van Arsdall</b>			13b. MOTHER'S MAIDEN NAME <b>Sallie Houc hin</b>		14. NAME OF HUSBAND OR WIFE <b>Samuel -Decea sed</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Lola M c Guire 105 S 7th Blue Springs Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardio-Vasc. Dis.</b>							<b>10 yrs.</b>
DUE TO (c)							
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"/> N. <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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year							
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 <b>Dec 1, 1959</b> to <b>Dec 17, 1960</b> and last saw her <b>Dec 17, 1960</b> alive on <b>Dec 17, 1960</b> Death occurred at <b>6:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>AD Eshelman, M.D.</b>			22b. ADDRESS <b>8306 E New 40th Hwy Independence Mo.</b>		22c. DATE SIGNED <b>Dec 19, 1960</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec 19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Springs Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Blue Springs Mo</b>			
24. FUNERAL DIRECTOR <b>Webb Funeral Home Blue Springs Mo</b>				25. DATE RECD. BY LOCAL REG. <b>12-19-60</b>		26. REGISTRAR'S SIGNATURE <b>Lauer Craig</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 William F. ...

Licensed Embalmer No. 473

P. O. Address Blue Spring

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.