

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046518

FILED VS DEC 28 1960 50

Registration District No. \_\_\_\_\_ Primary Registration District No. 5574 Registrar's No. 264

STATE FILE NUMBER

DED

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lee Van Buren</u>		Length of stay in lb. <u>2 1/2 yr.</u>	c. CITY OR TOWN <u>Lee Summit</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lake Lotawana</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. # 4</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Alice Schwartz</u>			4. DATE OF DEATH Month Day Year <u>12-21-1960</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>2-20-1894</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR 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>None</u>	11. BIRTHPLACE (City and state or country) <u>Larissa, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Samuel Troutman</u>		13b. MOTHER'S MAIDEN NAME <u>Harriett Quick</u>		14. NAME OF HUSBAND OR WIFE <u>Cliff D. Schwartz</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>491-20-8635A</u>		17. INFORMANT <u>C.D. Schwartz</u>	
				Address <u>Lee Summit 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>Acute Myocardial Infarction</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio Sclerosis Heart Disease</u> <u>5 years</u>		
DUE TO (c) <u>Essential Hypertension</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 checked="" 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 a.m. Month, Day, Year p.m.			
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 1955 to 12-21-60 and last saw her/him alive on 12-20-60  
Death occurred at 6:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John E. Linnell, D.O.</u>	22b. ADDRESS <u>25 East 12th K.C. Mo</u>	22c. DATE SIGNED <u>12-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee Summit Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Lee Summit, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C.D. O'Rademan &amp; Son Inc. K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-1960</u>	26. REGISTRAR'S SIGNATURE <u>D. B. Langford</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 Bert B. Bennett

Licensed Embalmer No. 4650

P. O. Address N.C., Me

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.