

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048604

FILED VS JAN 23 1961

393 Primary Registration District No. 1002 Registrar's No. 6594

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>K.C. NORTH</u>		Length of stay in 1b <u>10 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY NORTH</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5535 E. 48th N.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5535 E. 48th NORTH</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JEANETE</u> Middle <u>MAY</u> Last <u>FLEMING</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>29</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>OCT 22-1888</u>	9. AGE (last birthday) <u>72</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>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HORNBORNE, MO</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>ALBERT WARREN</u>			13b. MOTHER'S MAIDEN NAME <u>HATTA CRAIG</u>			14. NAME OF HUSBAND OR WIFE <u>WESTON FLEMING</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>WESTON FLEMING K.C. 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>Dormant Artery Occlusion</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</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 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. Month, Day, Year <u> </u> - <u> </u> - <u> </u>		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>5-1-60</u> to <u>12-29-60</u> and last saw her ^{her} alive on <u>12-29-60</u> Death occurred at <u>1120 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Charles H. Smith M.D.</u>				22b. ADDRESS <u>4130 W. Winn Rd K.C. 112</u>				22c. DATE SIGNED <u>12-30-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-31-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPLE CEM</u>			23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>				
24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons</u>			ADDRESS <u>N.K.C.</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L. Dwyer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Charles H. Smith

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John H. Kalsbeek
Licensed Embalmer No. 494
P. O. Address No. Kan

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