

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048646

FILED VS. JAN 23 1961

149

6591

STATE FILE NUMBER

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

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) <u>Kansas City</u>		Length of stay in 1b <u>32 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME (If NOT in hospital, give location) <u>General Hosp</u>		Institution Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>723 Troost</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>LESLIE</u> Last <u>Amson</u>			4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>60</u>			
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-1-89</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOTEL CLERK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOTELS</u>	11. BIRTHPLACE (City and state or country) <u>Australia</u>	12. CITIZEN OF WHAT COUNTRY <u>"unknown"</u>
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13a. FATHER'S NAME <u>Robert Amson</u>	13b. MOTHER'S MAIDEN NAME <u>Mathilda "UNKNOWN"</u>	14. NAME OF HUSBAND OR WIFE <u>"UNKNOWN"</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>H63-34-8939</u>	17. INFORMANT <u>Records & C. McGeneral Hospital</u>	Address <u>General Hospital</u>
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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>Dehydration AND Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from 12-25-1960 to 12-26-60 and last saw him alive on 12-26-1960
Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>2400 Kerree City</u>	22c. DATE SIGNED <u>12/27/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>	23b. DATE <u>12-31-60</u>	24. NAME OF CEMETERY OR CREMATOR <u>University of Kansas School of Dentistry</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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25. DATE RECD BY LOCAL REG. <u>12-30-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>
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DOCUMENT

BY AFFIDAVIT OF Frank Ellis MEDICAL CERTIFICATION

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 B. E. Wilcox

Licensed Embalmer No. 407

P. O. Address 2 E. 8th

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.