

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048693

FILED VS. JAN 23 1961

149

Primary Registration District No. 1002

Registrar's No.

6572

STATE FILE NUMBER

INDEXED

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Jackson</i>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>MO.</i> b. COUNTY <i>Jackson</i> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>KANSAS CITY</i>  |  | Length of stay in 1b<br><i>7yr</i>  | c. CITY OR TOWN <i>KANSAS CITY</i>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT IN hospital, give location)<br>HOSPITAL OR INSTITUTION <i>3416 CLEVELAND</i>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><i>3416 Cleveland</i>                       |  |
| 3. NAME OF DECEASED (Type or print)<br>First <i>LENA</i> Middle <i>FALLS</i> Last <i>FALLS</i>   |  |   | 4. DATE OF DEATH<br>Month <i>12</i> Day <i>-27-</i> Year <i>60</i>  |  |  |
| 5. SEX <i>Fe</i>   | 6. COLOR OR RACE <i>Col</i>            | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>1-1-1906</i>   | 9. AGE (last birthday)<br><i>54</i>  | IF UNDER 1 YEAR<br>Months <i>11</i> Days <i>27</i>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>MAID</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>PRIVATE FAMILY</i>  | 11. BIRTHPLACE (City and state or country)<br><i>Charleston Miss</i>  |  | 12. CITIZEN OF WHAT COUNTRY<br><i>USA</i>  |
| 13a. FATHER'S NAME<br><i>WALTER WILLIAMS</i>   |  | 13b. MOTHER'S MAIDEN NAME<br><i>BETTY YOUNG</i>   |   | 14. NAME OF HUSBAND OR WIFE<br><i>JAMES FALLS</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>no</i>  |  | 16. SOCIAL SECURITY NO.<br><i>409-50-8386</i>   |   | 17. INFORMANT<br><i>JACEY B. ODOM</i> Address <i>3416 Cleveland</i>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Hypertensive Ht Disease</i><br>DUE TO (b) <i>Interstitial Nephritis</i><br>DUE TO (c) <i>Generalized Arteriosclerosis</i><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.  |  | Month, Day, Year _____  |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <i>Dec 1-1960</i> and last saw her <i>Dec 27-60</i> and last saw him alive on <i>12-27-60</i><br>Death occurred at <i>3416 Cleveland</i> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |  |  |
| 22a. SIGNATURE<br><i>S. Wells MD</i> (Degree or title)   |  |   | 22b. ADDRESS<br><i>2122 E-15th St</i>   |  | 22c. DATE SIGNED<br><i>12-29-60</i>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>1-3-61</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>BLUERIDGE</i>  |  | 23d. LOCATION (City, town, or county) (State)<br><i>K.C. MO.</i>   |
| 24. FUNERAL DIRECTOR<br><i>Er. Sterling Bills</i>  |  | ADDRESS<br><i>1212 Vine</i>   |   | 25. DATE RECD. BY LOCAL REG.<br><i>12-29-60</i>  | 26. REGISTRAR'S SIGNATURE<br><i>H-L. Dwyer</i>   |

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. Sterling Bell

Licensed Embalmer No. 3170

P. O. Address 1212 W. H.

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.