

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 23 1967

60-048795

6638-60-048795

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6638 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City Mo</u>		Length of stay in 1b <u>1 Mo</u>		c. CITY OR TOWN <u>Leawood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3316 West 91st</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Delbert</u> Middle <u>L</u> Last <u>Paffenbach</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1960</u>				
5. SEX <u>Male</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>Apr 5 1918</u>	9. AGE (last birthday) <u>42</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wester Electric Co</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Accountant</u>		11. BIRTHPLACE (City and state or country) <u>South Bend Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Otto Paffenbach</u>			13b. MOTHER'S MAIDEN NAME <u>Fronader</u>			14. NAME OF HUSBAND OR WIFE <u>Ann S. Paffenbach</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 7/24/44 - 12/15/45</u>		16. SOCIAL SECURITY NO. <u>312-03-4699</u>		17. INFORMANT <u>Ann S. Paffenbach</u>		Address <u>3316 W 91st</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 <u>7 mo</u>	
IMMEDIATE CAUSE (a)		<u>Metastatic Carcinoma</u>						
DUE TO (b)		<u>Original Site unknown</u>						
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 _____ a.m. _____ p.m. Month, Day, Year _____								
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.) a _____ b _____		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>July 1956</u> to <u>Dec 29 1960</u> and last saw him alive on <u>Dec 29, 1960</u>				Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>John R. Whitman MD</u>			22b. ADDRESS <u>6314 Brookside Plaza</u>			22c. DATE SIGNED <u>12-30-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 26 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Johnson Co Memorial Gardens</u>		23d. LOCATION (City, town, or county) <u>Overland Park Mo.</u>				
24. FUNERAL DIRECTOR <u>D.W. Newcomers Sons Kansas City</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>				

DOCUMENT

MEDICAL CERTIFICATION

Whitman

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 _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Chester K Braem

Licensed Embalmer No. 493

P. O. Address K P M

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.