

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048825

FILED VS. JAN 23 1961

149

Primary Registration District No. 1002

Registrar's No.

6662

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>28 yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4630 Wornall Rd/</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth H.</b> Middle <b>H.</b> Last <b>Stanley</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1877</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HR Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Augusta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Charles T. Hollingsworth</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Heard</b>		14. NAME OF HUSBAND OR WIFE <b>Robert H. Stanley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Rufus Brown 4630 Wornall Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)		
20c. TIME OF INJURY Hour <b>11:05 p.m.</b> 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>1956</b> to <b>12-31-60</b> and last saw her alive on <b>12-31-60</b> Death occurred at <b>11:05 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>J. K. Skillman M.D.</b>			22b. ADDRESS <b>4635 Myrandotte Kansas City, Mo</b>		22c. DATE SIGNED <b>1-2-61</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Jan. 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Summerville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Augusta, Georgia</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure 3235 Gilham Plaza</b>			25. DATE RECD. BY LOCAL REG. <b>1-3-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

J. K. Skillman

**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 Elmer D. Triplett

Licensed Embalmer No. 4817

P. O. Address Kansas City

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