

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 23 1961

-80-048842
6566 STATE FILE NUMBER

Registration District No. 149 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>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>30 yrs.</u>	c. CITY OR TOWN <u>Kansas City</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>2310 Troost Ave.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2310 Troost Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>James M. Wesson</u> Middle Last		4. DATE OF DEATH <u>Dec 23, 1960</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal.</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>11/11/1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Cab Company</u>	9c. AGE (last birthday) <u>66</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>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cab Company</u>	10c. BIRTHPLACE (City and state or country) <u>Cester Point, Ark</u>
10d. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		11. BIRTHPLACE (City and state or country)	
13a. FATHER'S NAME <u>Sam Wesson</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Williams</u>	
14. NAME OF HUSBAND OR WIFE <u>Gerry Wesson</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>500-40-3756</u>		17. INFORMANT <u>Dwrey Wesson, 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>Chronic Myocarditis</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) <u>Arteriosclerosis</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 type="checkbox"/> No <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 Month, Day, Year s.m. p.m.	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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Respectfully, Coroner</u>		22b. ADDRESS <u>1618 Lydia Ave</u>		22c. DATE SIGNED <u>1/29/60</u>
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <u>12-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Jackson, Mo.</u>	
24. FUNERAL DIRECTOR <u>Badeau, Appleton & Jones, K.C., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-28-60</u>	26. REGISTRAR'S SIGNATURE <u>H-L. Dwrey</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF M. Tillman

37820 2701

15.2.6929

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 Consuelo Alejandra B...

Licensed Embalmer No. 4944

P. O. Address K.C., Mo.

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