

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014120

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 231

FILED MAY 10 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE	Length of stay in 1b 8 yrs	c. CITY OR TOWN INDEPENDENCE	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION INDEPENDENCE HOSPITAL		d. STREET ADDRESS (If outside, give location) 3902 So. River	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LYDIA Middle WHEELER Last NEISWANDER	4. DATE OF DEATH Month May Day 5 Year 1961
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5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1870	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) KEOKUK, IOWA	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Zephmeir Brown	13b. MOTHER'S MAIDEN NAME Mary Cowen	14. NAME OF HUSBAND OR WIFE Ben Neiswander- deceased
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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) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Ethel Whiston, 3902 So. River, Indep.
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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) Intestinal Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5 days 18 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterial Ulcer	
	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 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **Feb 1960** to **5/5/61** and last saw **her** alive on **5-4-61**
Death occurred at **5:20a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. D. Anderson MD	22b. ADDRESS 121 1/2 W. Lexington Indep, Mo	22c. DATE SIGNED 5/5/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5-8-61	23c. NAME OF CEMETERY OR CREMATORY HIGHLAND PARK CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, KANSAS
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24. FUNERAL DIRECTOR ADDRESS JOS. A. BUTLER'S SONS K.C.K	25. DATE RECD. BY LOCAL REG. 5-8-61	26. REGISTRAR'S SIGNATURE Alba L. Craig Deputy
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF

MAY 17 1951

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 Russell W Dennis

Licensed Embalmer No. 3462

P. O. Address K C K

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.