SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-021279

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2811

FILED JUN 21 1961

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Length of stay in 1b 3 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) K.C. Convalescent Home — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 114 No Bellaire — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First HARRY Middle LEE Last HAMLEY

4. DATE OF DEATH Month June Day 4 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10-12-87
9. AGE (last birthday) 73 — 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) Retired Machinist
10b. KIND OF BUSINESS OR INDUSTRY Gulf-Mobil R.R.
11. BIRTHPLACE (City and state or country) Slater Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Hamley
13b. MOTHER'S MAIDEN NAME Addie Hubbard
14. NAME OF HUSBAND OR WIFE Tina Hamley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Virginia Rupp — Address 114 No Bellaire

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 h
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Artery Atherosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left Inguinal Hernia, severe.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION Kansas City — COUNTY Jackson — STATE Mo

21. I attended the deceased from Jan 1961, to June 1 1961 and last saw him alive on June 1, 1961
Death occurred at 7:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) K. L. Shireman MD
22b. ADDRESS 4606 St John KC Mo
22c. DATE SIGNED 6-5-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE June 7 1961
23c. NAME OF CEMETERY OR CREMATORY Green Lawn
23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR Sheil Funeral Home — ADDRESS K.C. Mo
25. DATE RECD. BY LOCAL REG. 6-6-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

K. L. Shireman

JAN 30 1962

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 _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4954

P. O. Address _____

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.