SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-021305
STATE FILE NUMBER

AMENDED

FILED JUL 5 1961

Registrar's District No. 149 Primary Registration District No. 1002 Registrar's No. 3079

DATE AMENDED

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Johnson
c. CITY OR TOWN Merriam
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 9516 Johnson Dr.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Florence Middle: J. Last: Huber
4. DATE OF DEATH Month: June Day: 19, Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/18/1884
9. AGE (last birthday): 77
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Kansas City, Kansas
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William Jones
13b. MOTHER'S MAIDEN NAME: Belle Jones
14. NAME OF HUSBAND OR WIFE: David M. Huber
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: David M. Huber Address: Merriam, Kansas

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis - generalized — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Primary in Lt Breast — 1957
~~DUE TO (c)~~ Hypertension uterus leiomyoma — 15 yrs
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. ☐ 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.) Pathological fracture L femur 4-26-61
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.) Home
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 1955, to June 19 1961 and last saw her alive on June 19 1961
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

SHOULD READ

BY AFFIDAVIT OF

22a. SIGNATURE Frank B. Leitz (Degree or title) MD
22b. ADDRESS 1530 Pat Bldg Kansas City Mo
22c. DATE SIGNED 6-20-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6/21/61
23c. NAME OF CEMETERY OR CREMATORY Mapel Hill Cemetery
23d. LOCATION (City, town, or county) Kansas City, Kansas (State)
24. FUNERAL DIRECTOR E. Paul Amos ADDRESS Shawnee, Kansas
25. DATE RECD. BY LOCAL REG. 6-20-61
26. REGISTRAR'S SIGNATURE Ruth Long

ITEM NO.

(Licensed Embalmer's Statement on Reverse Side)

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 Eugene P. Limos

Signature of Student Embalmer

Licensed Embalmer No. 5023

P. O. Address Shawnee, 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.