SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-029468

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4082

FILED AUG 31 1961

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: 40 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1239 Vine Apt 6
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1239 Vine Apt. 6
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHN; Middle; Last MADISON
4. DATE OF DEATH: Month 8; Day 12; Year 61

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8-4-1870
9. AGE (last birthday): 91 yrs
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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Roseport, Missouri
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Benton Madison
13b. MOTHER'S MAIDEN NAME: Harriett McClure
14. NAME OF HUSBAND OR WIFE: Ida Madison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
17. INFORMANT: Cassie Seargent
Address: 1239 Vine Apt 6 Dau.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 0
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; 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 (Date of filing): L. M. Tillman M.D. Deputy Cor
22b. ADDRESS: Kansas City Mo.
22c. DATE SIGNED: 8-16-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8-18-61
23c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Lawn
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR: Watkins Bros. Funeral Home
ADDRESS: 18th & Benton
25. DATE RECD. BY LOCAL REG.: 8-16-61
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

L. M. Tillman

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 Frank R. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Boston

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.