

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4598-61-032735
STATE FILE NUMBER

AMENDED

Registration District No. 4-1961-49 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTTE				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY			Length of stay in lb 26 days		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Newberry's Nursing Home 3215 Cambell				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 2543 Alden		
3. NAME OF DECEASED (Type or print) First MATTIE Middle BENSON Last				4. DATE OF DEATH Month Sept Day 14, Year 1961				
5. SEX female		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/20/1893		
9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator			10b. KIND OF BUSINESS OR INDUSTRY Bell Tele. Co		11. BIRTHPLACE (City and state or country) unknown		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Isaac Benson				13b. MOTHER'S MAIDEN NAME Hattie Snow		14. NAME OF HUSBAND OR WIFE none		
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.		17. INFORMANT Mr Eugene Bell 2220 N. 35th K.C.K		
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 arterial thrombosis							INTERVAL BETWEEN ONSET, AND DEATH 48 hrs	
DUE TO (b) Arteriosclerotic cardiovascular disease							10 yrs.	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inanition. Senility						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 a.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 Aug 21, 1961 to 9/14/61 and last saw her alive on 9-13-61				Death occurred at 12:10PM m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) James W. Fowler MD				22b. ADDRESS Prof. Bldg. K.C.Mo.		22c. DATE SIGNED 9/15/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 9/16/61		23c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Kansas		
24. FUNERAL DIRECTOR JOS. A. BUTLER'S SONS K.C.K				25. DATE RECD. BY LOCAL REG. 9-15-61		26. REGISTRAR'S SIGNATURE Ruth Long		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF James W. Fowler

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 _____



Licensed Embalmer No. 3426 Mo

P. O. Address K.C. Kansas

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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.