

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

5477-61-040997
STATE FILE NUMBER

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

FILED NOV 17 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 68 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Healey Provident Hospital		d. STREET ADDRESS (If outside, give location) 1508 Forest Apt. 23	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Bertha Middle A. Last Crisp			4. DATE OF DEATH Month 10 Day 30 Year 61				
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-20-1893	9. AGE (last birthday) 68 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) Maid		10b. KIND OF BUSINESS OR INDUSTRY Gov. S. A.		11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE J. L. Crisp			
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. 2-3-66000		17. INFORMANT Address Bulah Inghram 1508 Forest Apt. 23			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchiectasis with		INTERVAL BETWEEN ONSET AND DEATH 8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) superimposed pneumonitis		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) none	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ none			

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.) Kansas city, Jackson, mo	20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas city, Jackson, mo	
21. I attended the deceased from 10/2/61 to 10/30/61 and last saw ^{or} alive on 10/30/61 Death occurred at 337A on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) John H. Wells MD		22b. ADDRESS 3718 Prospect		22c. DATE SIGNED Nov 3, 61	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE Nov. 3, 1961		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	
23d. LOCATION (City, town, or county) Kansas City, Mo.		23e. DATE RECD. BY LOCAL REG. 11-2-61		23f. REGISTRAR'S SIGNATURE Ruth Long	

24. FUNERAL DIRECTOR ADDRESS C. E. Davis T.C. mo.		25. DATE RECD. BY LOCAL REG. 11-2-61		26. REGISTRAR'S SIGNATURE Ruth Long	
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John H. Wells

ITEM NO. SHOULD READ

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 Landis K. Jackson

Licensed Embalmer No. 4852

P. O. Address K. C. Mo.

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.