

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041335

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5553

STATE FILE NUMBER

AMENDED

FILED NOV 17 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>19 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Allbritton Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1015 Harrison</b>	
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>White</b> Last <b>White</b>			4. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-1881</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (City and state or country) <b>FLORENCE Alabama</b>	
12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		13a. FATHER'S NAME <b>Dan Ingram</b>		13b. MOTHER'S MAIDEN NAME <b>Sophie Tucker</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		
17. INFORMANT Address <b>Helen H. White 1012 Troost</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>not known</b>		
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			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>None</b>		
20c. TIME OF INJURY Hour <b>9:00</b> m. <b>pm</b> Month, Day, Year <b>Nov 5 1961</b>			20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK <input checked="" type="checkbox"/> <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		COUNTY <b>Jackson</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>9:50 AM 11/20/61</b> to <b>5:00 PM 11/20/61</b> and last saw him alive on <b>5 Nov 61</b> Death occurred <b>9:50 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or informant) <b>John H. Wells MD</b>			22b. ADDRESS <b>3718 Prosper</b>		22c. DATE SIGNED <b>11/16/61</b>
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE <b>11-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Lawn</b>		23d. LOCATION (City, town, or county) <b>K.C. Mo.</b>
24. FUNERAL DIRECTOR <b>Jones &amp; Stevens 2315 Linwood</b>			25. DATE RECD. BY LOCAL REG. <b>11-6-61</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John H. Wells

**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. 48  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James A. Jones

Licensed Embalmer No. 4449

P. O. Address 2315 Frank  
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.