

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044941

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5977 STATE FILE NUMBER

FILED DEC 18 1961

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 1b 3 Weeks	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 Albritton Nursing Home 3001 Woodland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 432 Quindaro Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First **Bernard** Middle **James** Last **Nesbitt** 4. DATE OF DEATH Month **11/** Day **26/** Year **1961**

5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/6/91	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Santa	10b. KIND OF BUSINESS OR INDUSTRY Fee, Railroad	11. BIRTHPLACE (City and state or country) Alabama	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE May Della Nesbitt
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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 Address Mrs M.D.. Nesbitt K.C. Kansas
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Recurrent Cerebral Thromboses**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Generalized arteriosclerosis**

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Chronic Brain Syndrome**

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes N. Unknown

INTERVAL BETWEEN ONSET AND DEATH **7-10 days**

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____
a.m. _____ p.m. **none**

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I, attended the deceased from **Nov 3, 61** to **11-26/61** and last saw her/him alive on **11-25/61**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Printer or title) John H. Wells MD	22b. ADDRESS 3718 Prospect	22c. DATE SIGNED 11/27/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-30-61	23c. NAME OF CEMETERY OR CREMATORY Went Lawn	23d. LOCATION (City, town, or county) (State) Kansas City, MO
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24. FUNERAL DIRECTOR ADDRESS Bailey Funeral Home, K.C. Kansas	25. DATE RECD. BY LOCAL REG. 11-28-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

DOCUMENT

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. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hazel M. Hendrix

Licensed Embalmer No. 4943

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.