

Health, Welfare  
Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009258

STATE FILE NUMBER

1288

FILED MAR 26 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1288

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-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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>K C Convalescent</b>		Length of stay in lb <b>54 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>6238 E 15th St Terr</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>WILLIAM ASKINS</b>			4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 29 1879</b>	9. AGE (in years less birthday) <b>79</b>	10. UNDER 1 YEAR Months <b>1</b> Days <b>10</b>	11. UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance Man</b>	11. BIRTHPLACE (City and state or country) <b>Garard Co Kentucky</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Williams S Askins</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Duncan</b>	14. NAME OF HUSBAND OR WIFE <b>Mattie Askins</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>497-14-2037</b>	17. INFORMANT <b>Mrs Mattie Askins</b>	Address <b>6238 E 15th St Terr KC Mo</b>
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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) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerosis</b>	<b>6 years</b>
	DUE TO (c) <b>Diabetes</b>	<b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour <b>9:45 AM</b> a.m. <b>9</b> p.m. <b>45</b>	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 <b>Kansas City</b>	COUNTY <b>Missouri</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>3-7-59</b> to <b>3-10-59</b> and last saw her/him alive on <b>3-10-59</b> Death occurred at <b>9:45 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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21a. SIGNATURE <b>Frank Paul Laurencz</b> (Degree or title) <b>MD</b>	21b. ADDRESS <b>428 S White Ave</b>	21c. DATE SIGNED <b>3-10-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 13 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR <b>Sheil Funeral Home</b>	ADDRESS <b>Kansas City Mo</b>	25. DATE RECD. BY LOCAL REG. <b>3-11-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

Frank Paul Laurencz MD  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

**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. 4954 .....

P. O. Address X.P. 277 .....

**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.**