

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024499

FILED VS AUG 12 1959

Registration District No. 22 Primary Registration District No. 3013 Registrar's No. 135

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>No. K.C.</u>		Length of stay in lb <u>18 mo.</u>	c. CITY OR TOWN <u>No. K.C.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No. K.C. Memorial</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>532 E. 28th AVE</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>A.</u> Last <u>DOERSAM</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1871</u>	9. AGE (last birthday) <u>88</u>	10. UNDER 1 YEAR IF UNDER 24 HR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Leavenworth Ks.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Peter John Doersam</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Zix</u>		
14. NAME OF HUSBAND OR WIFE <u>Nettie Doersam</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>510-16-3428</u>		
17. INFORMANT <u>MRS. C.A. Goodman</u>		Address <u>of the Home</u>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia, Right</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage, Left</u>		<u>2 wk.</u>
DUE TO (c) <u>Generalized Arterio-Sclerosis 10 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 checked="" type="checkbox"/> NO <input 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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 7-31-1959 to 8-3-59 and last saw him alive on 8-3-59
Death occurred at 1:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Amel Boone MD</u> (Degree or title)		22b. ADDRESS <u>2025. Swift N.K.C. 16 Mo.</u>		22c. DATE SIGNED <u>8-4-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>8-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT MUNCIE Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Leavenworth, Ks.</u>	
24. FUNERAL DIRECTOR <u>Sexton FUNERAL Home</u> ADDRESS <u>Lev. Ks.</u>		25. DATE RECD. BY LOCAL REG. <u>8-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

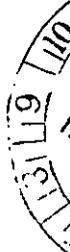
Dr. Boone

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *John V. Henrich*
Licensed Embalmer No. *484*
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.