

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024987

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3278 STATE FILE NUMBER

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) <b>Kansas</b>			Length of stay in 1b <b>70 Yrs</b>	c. CITY OR TOWN <b>Kansas</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>5925 Rockhill Rd.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5925 Rockhill Rd.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First Margaret Middle B. Last Beckenhaupt</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6-14-1866</b>	9. AGE (last birthday) <b>93</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b>	IF UNDER 24 HR Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Cincinnati, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>John Beckenhaupt</b>			13b. MOTHER'S MAIDEN NAME <b>Carolyn Peters</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>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Martin Stewart - 5511 Wayne</b> Address		
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>Senility</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.							
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 <u>1955</u> to <u>July 3, 1959</u> and last saw her <u>alive</u> on <u>July 2, 1959</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>John R. Whiteman</i> (Signed or title)				22b. ADDRESS <u>6314 Brookside Place</u>		22c. DATE SIGNED <u>7-4-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City, Mo.</b>		(State)
24. FUNERAL DIRECTOR <b>MELLODY-McFEELEY-EYLAR</b> <b>WOODLAND &amp; LINWOOD</b>				25. DATE RECD. BY LOCAL REG. <b>7-6-59</b>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	

DOCUMENT

BY AFFIDAVIT OF  
John R. Whiteman  
MEDICAL CERTIFICATION

Dr. John R.  
6. 214 R...

check with I  
Hospital at  
to see if  
cert is signed

**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 Melvin Barto

Licensed Embalmer No. 490

P. O. Address R. E. M.

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.