

RIVISION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025386

FILED VS AUG 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3756

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>3 Mo - 20 da</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K. C. TUBERCULOSIS HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9224 Meade</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>F.</u> Last <u>RIDER</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-1995</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOKIE MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NATL BISQUIT Co</u>	11. BIRTHPLACE (City and state or country) <u>Kansas, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>WALTER RIDER</u>		13b. MOTHER'S MAIDEN NAME <u>NELLIE MONROE</u>		14. NAME OF HUSBAND OR WIFE <u>MARCELLA RIDER</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>487-09-5121</u>	17. INFORMANT Address <u>Mrs Marcella Rider 9224 Meade</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>Pulmonary Tuberculosis</u>		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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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.) <u>f</u>
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

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 <u>KE</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
21. I attended the deceased from <u>4-11-1959</u> to <u>8-1-1959</u> and last saw <u>him</u> alive on <u>8-1-59</u> Death occurred at <u>10:04 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Edward P. Allomare M.D.</u>	22b. ADDRESS <u>KETB Hospital</u>	22c. DATE SIGNED <u>8-1-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>KE MO</u>
24. FUNERAL DIRECTOR <u>Geo. C. CARSON & Sons, INDEP. MO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>	26. REGISTRAR'S SIGNATURE <u>neva murrell</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *P. Kenneth Patterson*

Licensed Embalmer No. 4697
P. O. Address Indy 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.