RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-025444

FILED VS JUL 27 1959 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3374

STATE FILE NUMBER

IDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 21 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Sidewalk 1210 Broadway St. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1412a Broadway St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle E. Last SOUTHWICK

4. DATE OF DEATH: Month July Day 4 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐
8. DATE OF BIRTH: 6-21-89
9. AGE (last birthday): 70 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hospital Employee
10b. KIND OF BUSINESS OR INDUSTRY: K.C.T.B. Hosp.
11. BIRTHPLACE (City and state or country): Oskaloosa, Iowa
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: William Southwick
13b. MOTHER'S MAIDEN NAME: Amanda Fenewick
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I
16. SOCIAL SECURITY NO.: 490-16-3177
17. INFORMANT Address: Investigation & Family

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hugh H. Owens Coroner
22b. ADDRESS: 1034 Rialto Bldg
22c. DATE SIGNED: 7-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-9-1959
23c. NAME OF CEMETERY OR CREMATORY: State Military Cemetery
23d. LOCATION (City, town, or county) (State): Marshalltown, Iowa

24. FUNERAL DIRECTOR ADDRESS: WEILERT FUNERAL HOMES(S)K.C., MO.
25. DATE RECD. BY LOCAL REG.: 7-9-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Hugh H. Owens

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_____ Signed B. E. Weibel

Signature of Student Embalmer

Licensed Embalmer No. 4075

P. O. Address L.C.S.N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.