

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS JUL 27 1959**

**59-025505**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3376 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b> c. CITY OR TOWN <b>Leawood</b> d. STREET ADDRESS (If outside, give location) <b>9826 State Line</b>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>KENNETH</b> Middle <b>M.</b> Last <b>WHITE</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>9,</b> Year <b>1959</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec. 26, 1911</b>	<b>9. AGE (last birthday)</b> <b>48</b>	IF UNDER 1 YEAR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Musican</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Keokuk, Iowa</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>Lawrence L. White</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mabel Miller</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Alice Olivette White</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>491-019434</b>		<b>17. INFORMANT</b> Address <b>9826 State Line, Leawood, Kansas.</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>  <b>3 years</b>
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
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>	
<b>21. I attended the deceased from</b> <u>10-10-58</u> to <u>7-9-59</u> and last saw <u>her</u> alive on <u>7-9-59</u> Death occurred at <u>7:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <b>Martin J. Mueller M.D.</b>			<b>22b. ADDRESS</b> <b>535 Angye Blvd KC MO.</b>		<b>22c. DATE SIGNED</b> <b>7-9-59.</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>7-11-59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Moriah</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>FREEMAN MORTUARY, Kansas City, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>7-9-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>New Marshall</b>

DOCUMENT

BY AFFIDAVIT OF MARTIN J. MUELLER MEDICAL CERTIFICATION

THAMES

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 J. P. Green

Licensed Embalmer No. 19

P. O. Address F. O.

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.