

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025575

FILED VS JUL 21 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 154

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie</b>		Length of stay in 1b <b>4 years</b>		c. CITY OR TOWN <b>Kansas City</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>Jackson County Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>723 Cambridge</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Divers</b> Last <b>Divers</b>			4. DATE OF DEATH Month <b>July</b> Day <b>2</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>3/11/1883</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>76</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>***** MO</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Indep. Records Jackson County Hosp.</b>				
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>Arterio Sclerotic Heart Disease</b> DUE TO (b) <b>Generalized Arterio-Sclerosis</b> DUE TO (c) <b>Generalized Arterio-Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						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. <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 <b>5:25</b> a.m. <b>A.</b> Month, Day, Year <b>6-17-59</b>	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 <b>7-2-59</b>	COUNTY <b>7-2-59</b>	STATE <b>7-2-59</b>		
21. I attended the deceased from <b>5:25 A.</b> to <b>7-2-59</b> and last saw her/him live on <b>7-2-59</b> . Death occurred at <b>5:25 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Phyllis Laper M.D.</b>			22b. ADDRESS <b>Leas Summit Mo</b>			22c. DATE SIGNED <b>7/2/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Anatomical</b>	23b. DATE <b>8/2/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>University of K.C.</b>	23d. LOCATION (City, town, or county) <b>Kansas City Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Langsford Funeral Home</b>			25. DATE RECD. BY LOCAL REG. <b>8/2/59</b>	26. REGISTRAR'S SIGNATURE <b>W. Langsford</b>			

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 W. B. Langford  
Licensed Embalmer No. 383  
P. O. Address Leis Sun

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