

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028937

FILED VS AUG 21 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3816 STATE FILE NUMBER

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| 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>52 yrs.</u> | c. CITY OR TOWN <u>Kansas City</u> |
| c. FULL NAME OF (If NOT in hospital, give location) <u>3238 Nicholson</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3238 Nicholson</u> |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|---|---|---|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>AMPE</u> Last <u>AMPE</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>59</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>7/18/1894</u> | 9. AGE (last birthday) <u>85</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESIGNED FOREMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dickey Clay Co.</u> | 11. BIRTHPLACE (City and state or country) <u>Belgium</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>Francis Ampe</u> | | 13b. MOTHER'S MAIDEN NAME <u>Barbara Fleming</u> | | 14. NAME OF HUSBAND OR WIFE <u>FERONIE Planskert</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>487-01-2540</u> | 17. INFORMANT Address <u>MRS FERONIE AMPE 3238 Nicholson</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>Lobar Pneumonia</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) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis, Nephrosclerosis</u> | | 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 | |
|---|--|--|--|

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| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | 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 | COUNTY STATE |

21. I attended the deceased from 1-12-58 to 8-5-59 and last saw her/him alive on 8-4-59
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|----------------------------|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>J. A. Owens M.D.</u> | | 22b. ADDRESS <u>1034 Prairie Bldg</u> | | 22c. DATE SIGNED <u>8-6-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>8/8/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Oliver Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u> | | ADDRESS <u>KCMO</u> | 25. DATE RECD. BY LOCAL REG. <u>8-7-59</u> | 26. REGISTRAR'S SIGNATURE <u>Neve Minichell</u> |

DOCUMENT

MEDICAL CERTIFICATION

H. OWENS

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 Richard E. Carroll

Licensed Embalmer No. 4827

P. O. Address KC Mo.

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