

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028942

FILED VS SEP 1 1959

3944

STATE FILE NUMBER

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

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) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>55 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8200 Indyp. Ave.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8200 Indyp. Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Green</u> Last <u>Ashurst</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>13</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 26 - 1867</u>	9. AGE (last birthday) <u>90</u> UNDER 1 YEAR IF UNDER 24 HR 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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Pari, Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Nicholas R. Talbott</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Kennedy</u>		14. NAME OF HUSBAND OR WIFE <u>Leonidas B. Ashurst</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>496-16-9686 D</u>	17. INFORMANT Address <u>8200 Indyp. Ave.</u> <u>Miss Sallie Ashurst K.C. Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u>					<u>Chronic</u>
DUE TO (b) <u>Generalized Arteriosclerosis</u>					<u>Chronic</u>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Arteriosclerosis</u>					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 <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 <u>October 23, 1949</u> to <u>August 13, 1959</u> last saw her/him alive on <u>Nov 27, 1958</u> Death occurred at <u>3:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. H. Hiteason</u>			22b. ADDRESS <u>504 W. Maple</u>		22c. DATE SIGNED <u>8/13/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 17 - 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blackburn Cem.</u>		23d. LOCATION (City, town, or county) <u>Blackburn Mo.</u>	
24. FUNERAL DIRECTOR <u>C. D. Blackman & Son Inc. 1119 Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-14-59</u>	26. REGISTRAR'S SIGNATURE <u>Neval Minshall</u>	

DOCUMENT

BY AFFIDAVIT OF W. H. HICKERSON MEDICAL CERTIFICATION

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.C. Quine

Licensed Embalmer No. 4879

P. O. Address K.C., 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.