

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029053

FILED VS AUG 21 1959 / 49

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3785

STATE FILE NUMBER

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Length of stay in 1b 37 yrs | | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WHEATLEY HOSPITAL | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2024 Woodland | |
| 3. NAME OF DECEASED (Type or print) DORA | | First Middle Last ALICE EASON | | 4. DATE OF DEATH August 2, 1959 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7-9-1894 | |
| 9. AGE (last birthday) 65 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Forest City, Arkansas | | 11. BIRTHPLACE (City and state or country) USA | |
| 12. CITIZEN OF WHAT COUNTRY USA | | | | 13a. FATHER'S NAME Oliver Gipson | | 13b. MOTHER'S MAIDEN NAME Unknown | |
| 14. NAME OF HUSBAND OR WIFE Clarence Eason | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) {If yes, give war or dates of service} NO | | | |
| 16. SOCIAL SECURITY NO. NONE | | | | 17. INFORMANT Address Mattie Lee 2914 Brooklyn 2nd Floor | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis with Dehydration | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7-20 to 28 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | DUE TO (b) | |
| | | | | | | DUE TO (c) | |
| 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 Month, Day, Year a.m. p.m. | | | | | | | |
| 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>July 22, 1959</u> to <u>Aug 2, 1959</u> and last saw ^{her} him alive on <u>Aug. 2, 1959</u> Death occurred at <u>11:45</u> P on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>G. C. Turney M.D.</i> | | | | 22b. ADDRESS 1433 E. 19th St. | | 22c. DATE SIGNED 8-4-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-6-59 | | 23c. NAME OF CEMETERY OR CREMATORY Highland | | 23d. LOCATION (City, town, or county) (State) Kans. City, Missouri | |
| 24. FUNERAL DIRECTOR ADDRESS Watkins Bros. Funeral Home 18th & Benton | | | | 25. DATE RECD. BY LOCAL REG. 8-5-59 | | 26. REGISTRAR'S SIGNATURE <i>Walter Munchel</i> | |

DOCUMENT

MEDICAL CERTIFICATION

G. Turner

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 _____
Michael Green

Licensed Embalmer No. 4721

P. O. Address 18th YB

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.