

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032509

FILED VS. SEP 23 1959 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 4259

STATE FILE NUMBER

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> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>6 weeks</b>		c. CITY OR TOWN <b>Independence</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>Heartstone Nursing home</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1311 S. Pleasant</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH JANE OHMIE</b>				4. DATE OF DEATH Month Day Year <b>Aug. 29, 1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12/15/64</b>	9. AGE (last birthday) <b>94</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Badstown, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Frank Taylor</b>			13b. MOTHER'S MAIDEN NAME <b>Matilda Doss</b>		14. NAME OF HUSBAND OR WIFE <b>William F. Ohmie</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Veda L. Sapp Humansville, Mo.</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>Cerebral Hemorrhage 1 day</b> DUE TO (b) <b>arteriosclerosis 8 years</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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 type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.	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 <b>7-19-59</b> to <b>8-29-59</b> and last saw her <b>8-29-59</b> him alive on <b>8-29-59</b> Death occurred at <b>1095 12th</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Frank Paul Laurenciano MD</b>				22b. ADDRESS <b>428 S. white ave</b>		22c. DATE SIGNED <b>8-29-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lound Grove Cemetery</b>		23d. LOCATION (City, town, or county) <b>Independence, Mo.</b>			
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons</b>			ADDRESS <b>Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Meva Marshall</b>		

DOCUMENT

BY AFFIDAVIT OF FRANK PAUL LAURENCIANO, M.D. 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 Dean W. Hoff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.