

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032664

FILED VS SEP 25 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4399

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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>Mo.</u> b. COUNTY <u>JACKSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osteopathic Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>2400 E 35th St</u> | |

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|---|----------------------------------|---|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>FLORINDA</u> Middle <u>T.</u> Last <u>Witherspoon</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>7</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>Nov. 11, 1872</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 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>---</u> | | 11. BIRTHPLACE (City and state or country) <u>Monroe County Mo.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>John T. Tuttle</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARGARET Richardson Ross</u> | | |
| 14. NAME OF HUSBAND OR WIFE <u>W. Witherspoon</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>---</u> | | |
| 17. INFORMANT <u>Mrs. Stuart Walker</u> | | Address <u>8414 Meadow Lane</u> | | | | |

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| 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>Cardiac arrest</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized debility</u> DUE TO (c) <u>Sonility</u> | | | |
| 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 |

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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 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 <u>May 26, 1959</u> to <u>Sept. 7, 1959</u> and last saw her alive on <u>Sept 7, 1959</u> Death occurred at <u>3.24 P.M.</u> 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>Daniel M. Dupes, D.O.</u> | | 22b. ADDRESS <u>2105 Independence Hemo</u> | | 22c. DATE SIGNED <u>Sept 9 1959</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | <u>Sept 10, 1959</u> | <u>Mt. Moriah</u> | <u>KANSAS CITY Mo</u> | |
| 24. FUNERAL DIRECTOR <u>Kepley-Hinton</u> | ADDRESS <u>Raytown, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>9-9-59</u> | 26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u> | |

DOCUMENT

BY AFFIDAVIT OF Daniel M. Shapiro

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 John R. Sidm
Licensed Embalmer No. 453
P. O. Address Kansas

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.