

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036064

FILED VS OCT 16 1959/49

4755

STATE FILE NUMBER

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

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 45yrs	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION 101 East 36th St. Watson Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6830 Rockhill Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Nell Middle Maude Last Ball			4. DATE OF DEATH Month Oct. Day 1, Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-26-85	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Liberty, Neb.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Emmet Funston	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Thomas Ball
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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. UNKNOWN	17. INFORMANT THOMAS F. BALL Address 6830 ROCKHILL RD.
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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: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH hours
DUE TO (b) Cerebral Arteriosclerosis		
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)
Several previous strokes with quadriplegia & senility

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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from **1954** to **1 Oct 59** and last saw her alive on **24 Sept 59**
Death occurred at **12:10** **A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jean B. Willoughby (ID agree or wife)	22b. ADDRESS 3905 Main St KC 13 MO	22c. DATE SIGNED 10 Oct 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT 3, 1959	23c. NAME OF CEMETERY OR CREMATORY MT MORIAH CEM	23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.
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24. FUNERAL DIRECTOR D.W. Newcomers Sons Kansas City, Mo. ADDRESS _____	25. DATE RECD. BY LOCAL REG. 10-2-59	26. REGISTRAR'S SIGNATURE Elmer Marshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Jean B. Willoughby

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Vern Lawler

Licensed Embalmer No. 4915

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.