

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 10 1959

59-040028

STATE FILE NUMBER

Registration District No. 129 Primary Registration District No. 1002 Registrar's No. 5710

UNRECORDED

| | | | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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>3 Days</u> | | c. CITY OR TOWN <u>Raytown</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>Research Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>5914 Blue Ridge Blvd.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES ELLISON</u> | | | | 4. DATE OF DEATH Month Day Year <u>Nov. 26, 1959</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Apr. 9, 1892</u> | | 9. AGE (last birthday) <u>67</u> | | IF UNDER 1 YEAR Months Days Hours Min. <u>7 23</u> | | IF UNDER 24 HR | |
| 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>XXXXXXXXXXXX</u> | | 11. BIRTHPLACE (City and state or country) <u>Independence, Missouri</u> | | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>William Thomas Edwards</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Della Lemasters</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Samuel P. Ellison</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>XXXXXXXX</u> | | 17. INFORMANT Address <u>Samuel P. Ellison, Raytown, Missouri.</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>Cerebral vascular accident</u> | | | | | | | | | | <u>4 days</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) | | | |
| DUE TO (c) <u>Hypertensive cardiovascular disease</u> | | | | | | | | | | <u>unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <u>Lymphocytic leukemia</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 checked="" 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>23 Nov 59</u> to <u>26 Nov 59</u> and last saw her alive on <u>26 Nov 59</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Jack M Davis M.D.</u> | | | | | | 22b. ADDRESS <u>Raytown Mo</u> | | | | 22c. DATE SIGNED <u>27 Nov 59</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Nov. 28, 1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery Kansas City, Mo.</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>E. Clark Fagert, Raytown, Missouri.</u> | | | | | | 25. DATE RECD. BY LOCAL REG. <u>11-27-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JACK M. DAVIS

VIS APR 15 1961

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 Clark Hegert

Licensed Embalmer No. 3983

P. O. Address Raytown, Missouri

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.