

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. DEC 10 1959

59-040130

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 5671

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS City</u>		Length of stay in 1b <u>2 YRS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Colonial Nursing Home</u>		c. CITY OR TOWN <u>KANSAS City</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1912 W 37th Ave</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>ISAAC</u> Middle <u>Clinton</u> Last <u>HYRE</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>21</u> Year <u>1959</u>	
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5. SEX <u>Male</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>11-21-1869</u>	9. AGE (last birthday) <u>90 YRS</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Sec. of Union</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bill Posters Union</u>	11. BIRTHPLACE (City and state or country) <u>Palmyra Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>ISAAC HYRE</u>	13b. MOTHER'S MAIDEN NAME <u>MINNIE Palmer</u>	14. NAME OF HUSBAND OR WIFE <u>MINNIE W. HYRE</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>UNKNOWN Colonial Nursing Home Records</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: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs - 10 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>G.A.S.</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u>		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
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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.)
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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 _____
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21. I attended the deceased from July 5, 1959 to 11-21-59 and last saw her/him alive on 11-16-59.
Death occurred at 5:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>Benedict Caselund MD</u>	22b. ADDRESS <u>4000 Baltimore K. Mo 64111</u>	22c. DATE SIGNED <u>11-24-59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Nov 24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>	23d. LOCATION (City, town, or county) <u>KANSAS City</u> (State) <u>Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Gates Funeral Home 1901 Olathe Blvd Kan City, 3, Kan</u>	25. DATE RECD. BY LOCAL REG. <u>11-24-59</u>	26. REGISTRAR'S SIGNATURE <u>Newminshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 8 1930

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 Paul P. Williamson

Licensed Embalmer No. 5009

P. O. Address Overland Park, 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.

Case 6014.
HOOBALT.