

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1959

59-040302

5235

STATE FILE NUMBER

Registration District No. 149 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) Kansas City		Length of stay in lb UNKNOWN		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Walnut Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6134 Blue Hills Rd.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Henry Middle Harrison Last Platt				4. DATE OF DEATH Month Oct. Day 28 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-24-67	9. AGE (last birthday) 91	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) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Platt			13b. MOTHER'S MAIDEN NAME UNKNOWN Barnes		14. NAME OF HUSBAND OR WIFE Juanita E. Platt		
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. None		17. INFORMANT Address K.C.15 Mo. Mrs. Clifford Hutchinson 2901 Tomahawk Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) A.S.H.D. DUE TO (c) G.A.S.						INTERVAL BETWEEN ONSET AND DEATH 24 hrs legs 6 hrs	
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 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 Month, Day, Year a.m. p.m.							
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 an day of death to an day of death and last saw him live on day of death . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Clifford Hutchinson (Degree or title)				22b. ADDRESS 4000 Antenna		22c. DATE SIGNED 29 Oct 59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE OCT 31, 1959	23c. NAME OF CEMETERY OR CREMATORY UNION CEM		23d. LOCATION (City, town, or county) KANSAS CITY MO		(State)
24. FUNERAL DIRECTOR D.W. Newcomer Sons Kansas City, MO. ADDRESS				25. DATE RECD. BY LOCAL REG. 10-31-59		26. REGISTRAR'S SIGNATURE Irene Marshall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Bill Ford F. Casebolt

1-1-8084

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 *[Signature]*
Licensed Embalmer No. 4421
P. O. Address *[Address]*

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.