

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 30 1959

5980 STATE FILE NUMBER **0 4 4 3 4 6**

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	a. STATE Missouri	b. COUNTY Jackson
Length of stay in 1b 45 Yrs		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 Trinity Lutheran Hospital		d. STREET ADDRESS (if outside, give location) 5632 E 29th St	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First JOHN	Middle C	Last STEVENS	4. DATE OF DEATH	Month December	Day 9	Year 1959
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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 8/8/1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY U S Postal Service	11. BIRTHPLACE (City and state or country) Mount Rose So. Dakota	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME John Stevens	13b. MOTHER'S MAIDEN NAME Sarah Connley	14. NAME OF HUSBAND OR WIFE Julia Stevens (Dec)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW1	17. INFORMANT Patrick H Stevens Fargo So. Dakota
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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)	Cardiac Anterior Wall Infarct	14 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis & atherosclerosis	3 yrs
	DUE TO (c)	

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
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 **11/17/59** **9 A.M.** **to** **12/9/59** **and last saw him alive on** **12/8/59**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John M. Powers, M.D.	(Degree or title)	22b. ADDRESS 3304 Linwood Blvd	22c. DATE SIGNED 12/11/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/12/59	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 12-11-59	26. REGISTRAR'S SIGNATURE Blair Marshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John M. Powers

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 Thomas A. Smith

Licensed Embalmer No. 4954
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.