

# MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 4 3 8

FILED VS. DEC. 29 1959 <sup>50</sup>

Primary Registration District No. 5572 Registrar's No. 292

STATE FILE NUMBER

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie</b>		Length of stay in 1b <b>13 yrs.</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson County Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5818 East 10th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mattie</b>				First Middle Last <b>Burt</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>20</b> Year <b>1959</b>							
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>negro</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>?-? 1876</b>		<b>9. AGE (last birthday)</b> <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Unknown</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.</b>					
<b>13a. FATHER'S NAME</b> <b>Unknown</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Jackson County Negro Home, Lees Summit Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____				<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>12-15-59</u> to <u>12-20-59</u> and last saw her/him alive on <u>12-20-59</u> Death occurred at <u>11:05 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> <i>Philip M. D.</i> (Degree or title)				<b>22b. ADDRESS</b> <i>Lees Summit Mo</i>				<b>22c. DATE SIGNED</b> <i>12/21/59</i>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Anatomical</b>			<b>23b. DATE</b> <b>12-26-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>K.C. Western Dental Col.</b>			<b>23d. LOCATION (City, town, or county)</b> <b>Kansas City, Mo.</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Weilert's: 2332 Monitor Pl. K.C. Mo.</b>					<b>25. DATE RECD. BY LOCAL REG.</b> <b>12/24/59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>M.B. Langford</i>						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 B. E. Wulbert

Licensed Embalmer No. 4675

P. O. Address L. C. S. M.

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.