

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-001496**

**FILED VS. FEB 15 1960**

Registration District No. 148 Primary Registration District No. 1002 Registrar's No. 597

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Clay</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>40 yrs</b>		c. CITY OR TOWN <b>Kansas City North</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>Trinity Lutheran</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3921 N. Jackson</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>M.</b> Last <b>DENMAN</b>				4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>60</b>					
5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-92</b>	9. AGE (last birthday) <b>67</b>	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) <b>Pharmacist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>		11. BIRTHPLACE (City and state or country) <b>Hall County, Nebr.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Joseph A. Denman</b>			13b. MOTHER'S MAIDEN NAME <b>Belle Creason</b>			14. NAME OF HUSBAND OR WIFE <b>Aberdeen M. Denman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW#1 &amp; WW#2</b>			16. SOCIAL SECURITY NO. <b>487-07-3751</b>		17. INFORMANT Address <b>Robt. Denman, Mt. Ida, Arkansas</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transition</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of the esophagus</b>									
DUE TO (c) <b>c pulmonary metastases</b>									
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 <b>May 5, 1959</b> to <b>Jan. 31, 1960</b> and last saw him alive on <b>Jan. 31, 1960</b> Death occurred at <b>7:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Deceased or informant) <b>L.M. Roberts MD</b>				22b. ADDRESS <b>1906 Erie, North K.C. Mo</b>			22c. DATE SIGNED <b>2-1-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-3-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>				
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K C Mo</b>			25. DATE RECD. BY LOCAL REG. <b>2-2-60</b>		26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Roberts**

4

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Alvin R. Haun*

Licensed Embalmer No. 415

P. O. Address H. e. W.

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.