

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001949

FILED VS FEB 4 1960/49

382

STATE FILE NUMBER

Registration District No. 1002 Primary Registration District No. 1002 Registrar's No. 382

1002

| | | | | | | | | | |
|---|---|--|--|--|--|---|--|-------|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in 1b <u>60 YRS</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>42 West 58th Terr</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BLANCHE - TRABON</u> | | | | 4. DATE OF DEATH Month Day Year <u>JAN 21 - 1960</u> | | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY-25-1897</u> | 9. AGE (last birthday) <u>62</u> | IF UNDER 1 YEAR Months Days Hours | IF UNDER 24 HR Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wolkeamans</u> | | 11. BIRTHPLACE (City and state of country) <u>Odessa MO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.R.</u> | | |
| 13a. FATHER'S NAME <u>Robert Cobb</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Letha Wagner</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Louis Trabon</u> | | | |
| 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>495-07-8103</u> | | 17. INFORMANT Address <u>Louis Trabon 42 W. 58th Terr K.C. Mo</u> | | | | |
| 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 <u>Many years</u> | | |
| IMMEDIATE CAUSE (a) <u>Atrial Defect which</u> | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Right Ventricular Failure</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) | | | | | 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 checked="" 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.) | | | | | | |
| 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 | |
| 21. I attended the deceased from <u>5-8-1956</u> to <u>1-21-1960</u> and last saw her alive on <u>1-20-1960</u> Death occurred at <u>5 AM - 1-21-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u> | | | | 22b. ADDRESS <u>K.C. MO</u> | | | 22c. DATE SIGNED <u>1-22-60</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>1-23-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Missouri</u> | | | | |
| FUNERAL DIRECTOR <u>Dates Funeral Home</u> ADDRESS <u>1901 Olive Blvd. Kansas City 3, Kansas</u> | | | 25. DATE RECD. BY LOCAL REG. <u>1-22-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u> | | | | |

DOCUMENT

MEDICAL CERTIFICATION

Ketcham

BY AFFIDAVIT OF

Mr. Williams
Overland Park

FEB 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 *Paul R. Williamson*

Licensed Embalmer No. 5009

P. O. Address Overland Park

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.