

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006565

FILED VS. MAR. 3 1960 149

Primary Registration District No. 1002 Registrar's No. 922

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>KANSAS</b> b. COUNTY <b>WYANDOTTE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>33 days, 85 yrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DELORA REST HOME</b>				d. STREET ADDRESS (If outside, give location) <b>1046 GREELEY</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES R. SHERMAN</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</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>OCT 25, 1874</b>	
				9. AGE (last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED FURNITURE STORE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ERIE PA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>CHARLES A SHERMAN</b>			13b. MOTHER'S MAIDEN NAME <b>SARAH BROCKAWAY</b>			14. NAME OF HUSBAND OR WIFE <b>ONIA L SHERMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>514 30 7276</b>		17. INFORMANT <b>MR. C. ELLIS SHERMAN 6143 CHERRY ST.</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>PNEUMONITIS</b> DUE TO (b) <b>CARDIAC FAILURE</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 yrs.</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 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 <b>JAN 1960</b> to <b>FEB 11 1960</b> and last saw her/him alive on <b>JAN 9 1960</b> Death occurred at <b>7.40 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>J. Edward Slankard M.D.</b>				22b. ADDRESS <b>2121 Minnesota Kansas City, Kansas</b>		22c. DATE SIGNED <b>2-13-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB 15, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY KANSAS</b>	
24. FUNERAL DIRECTOR ADDRESS <b>J.D.W. NEWCOMER'S SONSK.C.MO.</b>				25. DATE RECD. BY LOCAL REG. <b>2-15-60</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

DOCUMENT

MEDICAL CERTIFICATION

Edward Slankard

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Harold B. Echter*

Licensed Embalmer No. 3035

P. O. Address *W. C. E. Co.*

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.