

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015117

FILED VS. APR 25 1960

149

Primary Registration District No. 1002

Registrar's No.

1899

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY CLAY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in lb 4 days		c. CITY OR TOWN Holt		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION OSTEOPATHIC HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRANCIS Middle ALLEN Last AMOS				4. DATE OF DEATH Month APRIL Day 4 Year 1960					
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-11-78	9. AGE (last birthday) 82 yr.	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) retired farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cedar Co., Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE MAUD M. AMOS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Maud Amos Holt, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH 1 day		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) debility & Chronic Brain Syndrome							weeks		
DUE TO (c) bedrest & Generalized Atherosclerosis							months		
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 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 March 31, 1960 to April 4, 1960 and last saw him alive on April 4, 1960 Death occurred at 11:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Verner Ames MD				22b. ADDRESS 926 E. 11th St.				22c. DATE SIGNED 4-4-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-4-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town, or county) (State) Rural Plattsburg, Mo.				
24. FUNERAL DIRECTOR Fry Funeral Home, Keosauqua, Mo			ADDRESS		25. DATE RECD. BY LOCAL REG. 4-4-60		26. REGISTRAR'S SIGNATURE Neva Marshall		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Verner J. Ames

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 *Lundell J. Am...*

Licensed Embalmer No. 4589
P. O. Address *Excelsior Springs*

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.