

RI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH

-60-015271

FILED VS APR 25 1960/47

1952

STATE FILE NUMBER

DEED

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

| | | | |
|--|--|---|---|
| 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> 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>50 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>2329 MONTGAL</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>2329 MONTGAL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | |
|--|------------------------------------|---|---|-------------------------------------|---|------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL MASON DREW</u> | | | 4. DATE OF DEATH Month Day Year <u>4-4-1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-28-1886</u> | 9. AGE (last birthday) <u>74</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOMES</u> | 11. BIRTHPLACE (City and state of country) <u>BUNCETON, MO.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>ISAAC DREW</u> | 13b. MOTHER'S MAIDEN NAME <u>SALLIE GREEN</u> | 14. NAME OF HUSBAND OR WIFE <u>VINITA DREW.</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>495-01-4170</u> | 17. INFORMANT <u>JESSIE ANDERSON, K.C., MO.</u> Address | |

| | | |
|---|--|---|
| 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 |
| IMMEDIATE CAUSE (a) | <u>Chronic Myocarditis</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ DUE TO (c) <u>Senility</u> | |
| 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 checked="" type="checkbox"/> N. <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 _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|---|--|
| 22a. SIGNATURE <u>[Signature]</u> Deputy Coroner | 22b. ADDRESS <u>1618 Lydia Ave.</u> | 22c. DATE SIGNED <u>4/5/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>4-8-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN</u> |
| 24. FUNERAL DIRECTOR <u>BROWN-HUDSON, K.P., MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>4-6-60</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. T. Tillman

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 Willard B. Pask

Licensed Embalmer No. 5013

P. O. Address KC Mo

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.