

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

**-60-015404**

**FILED VS MAY 5 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2156

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b>				<b>2. USUAL RESIDENCE</b> (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>1day</b>		c. CITY OR TOWN <b>KANSAS CITY</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>ST JOSEPH HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>23 S. 17th</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Laura</i> Middle <b>B</b> Last <i>Hopkins</i>				<b>4. DATE OF DEATH</b> Month <i>April</i> Day <i>15</i> Year <i>1960</i>									
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/20/1872</b>		<b>9. AGE</b> (last birthday) <b>88</b>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HR</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housework</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Steelville, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>					
<b>13a. FATHER'S NAME</b> <b>Abner Turnbaugh</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Dont know Ford</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Unk.</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> Address <b>Mrs Emma Resovich 23 S. 17th K.C.K</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-Vascular Accident</i>										INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis Generalized</i>													
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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____													
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		COUNTY _____		STATE _____					
<b>21. I attended the deceased, from _____ 1958, to _____ 4/15/60 and last saw her <del>her</del> alive on _____ 4/15/60</b> Death occurred at _____ 11:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <i>Edward P. Altomare M.D.</i>						<b>22b. ADDRESS</b> <i>2610 E 63rd St.</i>				<b>22c. DATE SIGNED</b> <i>4/15/60</i>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>		<b>23b. DATE</b> <b>4/19/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Maple Hill Cemetery</b>				<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City, Kansas</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>JOS. A. BUTLER'S SONS K.C.K</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <i>4-18-60</i>		<b>26. REGISTRAR'S SIGNATURE</b> <i>neva minshall</i>							

DOCUMENT

BY AFFIDAVIT OF Edward P. Altomare MEDICAL CERTIFICATION

**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 Beebe*

Licensed Embalmer No. 3426

P. O. Address Riverside

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.