

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 15 1960

-60-019278

DED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2860 STATE FILE NUMBER

|  |  |   |   |  |  |  |  |                              |
|--|--|---|---|--|--|--|--|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |  |  |                              |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>  |  | Length of stay in 1b<br><i>unknown</i>  |   | c. CITY OR TOWN <b>KANSAS CITY</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>GENERAL HOSP.</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>5920 WYANDOTTE ST.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                              |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Kate</b> Middle <b>S</b> Last <b>Baxter</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>MAY</b> Day <b>25</b> Year <b>1960</b>  |  |  |  |                              |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>SEPT 8, 1874</b>  |  | 9. AGE (last birthday)<br><b>85 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  | IF UNDER 24 HR<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AT HOME</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>PERRYVILLE KY.</b>          |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                  |                              |
| 13a. FATHER'S NAME<br><b>JAMES BALDEN</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>MINERVA PRESTON</b>                       |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>LEMUEL K. BAXTER</b>   |  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                    |  | 17. INFORMANT<br><b>MARJORY SPARLING 5920 WYANDOTTE</b><br>Address           |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>   |  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>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.<br><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<br>Hour a.m. p.m.<br>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>5-19-60</b> to <b>5-25-60</b> and last saw her/him alive on <b>5-25-60</b> .<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |  |  |  |  |                              |
| 22a. SIGNATURE<br><i>H.L. Dwyer MD</i> (Degree or title)   |  |   |   | 22b. ADDRESS<br><b>2400 Cherry</b>   |  |  | 22c. DATE SIGNED<br><b>5-27-60</b>   |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAY 28, 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MAPLE PARK CEM</b>               |  | 23d. LOCATION (City, town, or county) (State)<br><b>SPRINGFIELD MISSOURI</b> |  |  |                              |
| 24. FUNERAL DIRECTOR<br><b>D. W. NEWCOMER'S SONS KC. MO.</b><br>ADDRESS  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-27-60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><i>Neve Trinnabell</i>  |  |                              |

DOCUMENT

MEDICAL CERTIFICATION

H. L. Dwyer

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 John W. Holson

Licensed Embalmer No. 4889

P. O. Address J. S. 476.

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.