

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019321

FILED VS MAY 27 1960

2670

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. _____

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>	a. STATE <u>Missouri</u> b. 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>7 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>Northeast Restorium</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3525 Blue Ridge Blvd</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<u>ELIZABETH BUSTER</u>				<u>May 15 1960</u>			

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>10/27/1868</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HR Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Robert Allen</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah M Emery</u>	14. NAME OF HUSBAND OR WIFE <u>James R Buster</u>
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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>None</u>	17. INFORMANT <u>Mrs Blanche Brown 3525 Blue Ridge Blvd</u>
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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 <u>1 wk</u>
IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <u>Cerebral artery arteriosclerosis</u>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ Month, Day, Year _____
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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 <u>Kansas City Jackson Mo.</u>	COUNTY	STATE
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21. I attended the deceased from Jan 1958 to May 11 1960 and last saw her alive on May 7, 1960
Death occurred at 2:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	(Degree or title)	22b. ADDRESS <u>4606 St John's Church</u>	22c. DATE SIGNED <u>5-16-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 16 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Independence Missouri</u>
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24. FUNERAL DIRECTOR <u>Sheil Funeral Home Kansas City Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-16-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF Shlreman

VS MAY 27 1980

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.