

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUL 13 1960 149

=60-023184

3389

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>45 Years</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>Menorah Medical Center</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3212 Central</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GeNeVa</b> Middle <b>C.</b> Last <b>Graves</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-30-95</b>	9. AGE (last birthday) <b>64</b>	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) <b>Concession Stand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fred Harvey</b>		11. BIRTHPLACE (City and state or country) <b>Pittsfield, Pe nn.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		
13a. FATHER'S NAME <b>Walter Jordan</b>			13b. MOTHER'S MAIDEN NAME <b>Catherine Corcoran</b>			14. NAME OF HUSBAND OR WIFE <b>Fred Graves</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-28-6065</b>		17. INFORMANT <b>Mrs O.F. Jackson, 600 W 88th, Terr.</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Renal Insufficiency</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Multiple Renal Infarcts</b>							<b>3 Days</b>	
DUE TO (c) <b>Aortic Aneurysm Rupture</b>							<b>3 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive C-U Disease; Thrombosis left femoral artery</b>					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 checked="" 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 _____ a.m. _____ p.m. _____		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 _____ to <b>June 26, 1960</b> and last saw <sup>her</sup> <del>him</del> alive on <b>June 26, 1960</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or Title) <b>E. J. Twin, M.D.</b>			22b. ADDRESS <b>701 E. 63<sup>rd</sup>; K.C. 10, Mo.</b>			22c. DATE SIGNED. <b>6-27-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/29/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>		23d. LOCATION (City, town, or county) <b>Kansas City</b>		STATE <b>Mo</b>		
24. FUNERAL DIRECTOR'S ADDRESS <b>Mellody McGilley-Eylar Linwood &amp; Main; K.C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>6-28-60</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF E. J. Twin

**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 Wm H. [Signature]

Licensed Embalmer No. 5038

P. O. Address R. C. [Signature]

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.