

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027192

FILED VS JUL 26 1960

149

Primary Registration District No. 1002

Registrar's No. 3541

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 30 YEARS		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKE'S HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3685 SUMMIT STREET.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ella Middle V Last Tye				4. DATE OF DEATH Month JULY Day 5 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH FEB. 23, 1876	9. AGE (last birthday) 84	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) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (City and state or country) LIVINGSTON COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME REECE GIBSON			13b. MOTHER'S MAIDEN NAME SUSAN BUCHANAN		14. NAME OF HUSBAND OR WIFE DREW P. TYE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DONALD TYE		Address 1229 WEST 68TH TERRACE KANSAS CITY, MISSOURI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Distertrochantari fracture right femur DUE TO (b) Fall DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Congestive heart failure, ASHD					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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell at home					
20c. TIME OF INJURY Hour _____ s.m. _____ Month, Day, Year July 30, 1960	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.) Home		20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY STATE Jackson Missouri	
21. I attended the deceased from July 1, 1960 to July 5, 1960 and last saw her him alive on July 5, 1960 . Death occurred at 12:25 P.M. on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) John L. Barnard Jr. M.D.				22b. ADDRESS 431 1/2 W. C. Nichols Parkway		22c. DATE SIGNED July 6, 1960	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JULY 7, 1960	23c. NAME OF CEMETERY OR CREMATORY LOCK SPRINGS CEMETERY		23d. LOCATION (City, town, or county) LOCK SPRINGS MISSOURI			
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS			1331 ADDRESS BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 7-7-60		26. REGISTRAR'S SIGNATURE Neva Minshall	

DOCUMENT

BY AFFIDAVIT OF JOHN L. BARNARD, M.D. 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 Loman W. Houston

Licensed Embalmer No. 4889

P. O. Address A. C. Me.

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.