

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030742

FILED VS AUG 23 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4024

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 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>37 Years</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>OSTEOPATHIC HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3261 WARWICK</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle Last <u>POOL</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1899</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OPER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>	11. BIRTHPLACE (City and state or country) <u>OMAHA TEXAS</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>LEE POOL</u>	13b. MOTHER'S MAIDEN NAME <u>BEATRICE HENDERSON</u>	14. NAME OF HUSBAND OR WIFE <u>INA LEE POOL</u>	

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 Address <u>Mrs. INA LEE POOL, 3261 WARWICK</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: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 3/4 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Multiple myeloma</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) <u>Severe protein alterations in blood</u>	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
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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 <u>12:00 PM 1957</u> to <u>Aug 3, 1960</u> and last saw him alive on <u>Aug 3, 1960</u> Death occurred at <u>4:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Print name) <u>Raymond Hall D.O.</u>	22b. ADDRESS <u>926 E. 11th St. K.C. Mo.</u>	22c. DATE SIGNED <u>8-5-60</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Aug 5 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>
23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	24. FUNERAL DIRECTOR <u>MUENLEBACH</u>	25. DATE RECD. BY LOCAL REG. <u>8-5-60</u>
26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

Raymond Hall

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 *B. C. Nichol*

Licensed Embalmer No. 4997

P. O. Address K. C. W.

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.