

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030814

FILED VS AUG 23 1960

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 4097

STATE FILE NUMBER

DEED

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 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><b>45 YRS</b>   |  | c. CITY OR TOWN <b>KANSAS City</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St Joseph Hospital</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside give location)<br><b>2420 Linwood</b>  |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BESSIE</b> Middle <b>N.</b> Last <b>Stephens</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>8</b> - Day <b>5</b> - Year <b>1960</b>   |  |  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>white</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-26-1895</b>   | 9. AGE (last birthday)<br><b>65</b>                                      | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired)<br><b>HOUSEWIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>OSCEOLA, MO.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>  |   |
| 13a. FATHER'S NAME<br><b>HENRY S. GRIMES</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>ANNIE LEHOW</b>                                      |  | 14. NAME OF HUSBAND OR WIFE<br><b>E.E. Stephens</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>497-44 5362</b>   |  | 17. INFORMANT<br><b>E.E. Stephens 2420 Linwood K.C. Mo.</b>  |  |  |   |
| 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>BRONCHOPNEUMONIA BILATERAL</b><br>DUE TO (b) <b>CARCINOMA RECTUMI</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 DAYS</b>   |   |
| 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?<br>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"/><br>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<br>COUNTY _____ STATE _____   |   |
| 21. I attended the deceased from <b>7-18-60</b> to <b>8-5-60</b> and last saw her/him alive on <b>8-5-60</b><br>Death occurred at <b>11 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |  |  |  |  |   |
| 22a. SIGNATURE (Type name or title)<br><b>Edward P. Altomare M.D.</b>  |  |   |  | 22b. ADDRESS<br><b>2610 E. 63rd St KC Mo.</b>  |  | 22c. DATE SIGNED<br><b>8-8-60</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>8-8-1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Floral Hills Cemetery</b>                   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Mo.</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>Floral Hills Memorial Chapel</b>  |  |   | ADDRESS<br><b>K.C. Mo.</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>8-9-60</b>                            | 26. REGISTRAR'S SIGNATURE<br><b>H.S. Dwyer</b>   |   |

DOCUMENT

BY AFFIDAVIT OF Edward P. Altomare MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James D. Goldman

Licensed Embalmer No. 2714

P. O. Address K. P. Wis.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.