

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034685

FILED VS OCT 10 1960

149

Registration District No. 1002

Registrar's No. 4798

STATE FILE NUMBER

INDEXED

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 1 1/2 yrs		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 Home, 3738 Harrison St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3738 Harrison St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Brinsey Last Cleveland				4. DATE OF DEATH Month Sept Day 20 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 7/21/1861	9. AGE (last birthday) 99	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Wabash, Indiana		12. CITIZEN OF WHAT COUNTRY U. S.		
13a. FATHER'S NAME Silas Greenfield			13b. MOTHER'S MAIDEN NAME Elizabeth Kline			14. NAME OF HUSBAND OR WIFE Thomas B. Cleveland		
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 Dr. C. S. Cleveland, Jr. Kans. City, Mo. Address 3724 Troost				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebral Apoplexy						
		DUE TO (c) Arterio Sclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 99 years old					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 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.)					
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 Sept 8, 1960 to Sept 20, 1960 and last saw her ^{her} _{him} alive on Sept 20, 1960 Death occurred at 11:45 A am on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) C. S. Cleveland Jr., D. C.				22b. ADDRESS 3724 Troost		22c. DATE SIGNED Sept 20, 60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-22-60	23c. NAME OF CEMETERY OR CREMATORY Liberty Center Cemetery		23d. LOCATION (City, town, or county) Liberty Center, Iowa			
24. FUNERAL DIRECTOR W. W. Newcomer's Sons		ADDRESS 1351 Brusck Creek, K. C. Missouri.		25. DATE RECD. BY LOCAL REG. 9-21-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Cleveland**

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 Raymond M. Hall

Licensed Embalmer No. 4913

P. O. Address Indep. M.

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.