JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 27 1960

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 462 60-035148 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Independence — Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 9523 E. 32nd St. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1515 E. 37th St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First PAULINE Middle WILD Last CARROLL
4. DATE OF DEATH: Month Sept. Day 22 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/24/79
9. AGE (last birthday): 81 — 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: Domestic
11. BIRTHPLACE (City and state or country): New Jersey
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Robert Wild
13b. MOTHER'S MAIDEN NAME: Regina Buehler
14. NAME OF HUSBAND OR WIFE: Wm. J. Carroll
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Ruth Anne Wagner Address: 9523 E. 32nd Indep., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — Chr.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cardiac decompensation
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7-9-60, to 9-22-60 and last saw her alive on 9-18-60
Death occurred at 9:00 Hrs m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: David Elias (Degree or title) MD
22b. ADDRESS: 9306 E 40 Hwy Indep Mo
22c. DATE SIGNED: 9-22-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/24/60
23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri
24. FUNERAL DIRECTOR: Geo. C. Carson & Sons ADDRESS: Indep., Mo.
25. DATE RECD. BY LOCAL REG.: 9-24-60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed [illegible]
Signature of Student Embalmer

Licensed Embalmer No. 4697

P. O. Address [illegible]

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.