

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

5355-60-038247
5355 STATE FILE NUMBER

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

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 40 yrs.		c. CITY OR TOWN Kanaas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4414 Crisp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4414 Crisp		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maude Frances Albin				4. DATE OF DEATH Month Day Year October 24 1960				
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1899	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months <u>4</u> Days <u>29</u> Hours _____ Min. _____	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) Rochester, Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME George W. Clayton			13b. MOTHER'S MAIDEN NAME Minnie Stuplitz			14. NAME OF HUSBAND OR WIFE Samuel Harper Albin		
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. 493-12-3052		17. INFORMANT Samuel Albin		Address 4414 Crisp K.C.Mo.		
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 24 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arterio sclerosis chronic								
DUE TO (c)								
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. <input type="checkbox"/> Yes <input 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 <u>10-14-60</u> to <u>10-24-60</u> and last saw her <u>her</u> alive on <u>10-23-60</u> Death occurred at <u>9:00 A M</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) David J. Elias M.D.				22b. ADDRESS 9306 E 40 Hwy INDEP MO			22c. DATE SIGNED 10-24-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/26/60	23c. NAME OF CEMETERY OR CREMATORY Floral Hills 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. 10-25-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **David J. Elias**

0981 6 AON

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 Raymond G. Hobbs
Licensed Embalmer No. 420

P. O. Address Independent

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.