

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038566

FILED VS. NOV 9 1960

149

Registration District No.

Primary Registration District No. 1002

Registrar's No.

5265

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>DOA</b>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA. St Lukes Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>820 Shawnee Rd</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Lillian H.</b> Middle <b>Stephenson</b> Last			4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>60</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-98</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kans.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William H. Hutson</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah K. Dickason</b>	14. NAME OF HUSBAND OR WIFE <b>Clifford Stephenson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Bill Buschhusen</b> Address <b>2118 S. 35th</b> ( <b>Daughter</b> )
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>		<b>1 Min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Myocardial Ischemia</b>	<b>2 hrs</b>
	DUE TO (c) <b>Coronary Occlusion</b>	<b>2-3 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral &amp; Coronary Arteriosclerosis</b>		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.)
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20c. TIME OF INJURY Hour <b>3:30</b> a.m. p.m.	Month, Day, Year <b>Jan. 1 60</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Kansas</b>	STATE
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21. I attended the deceased from **Jan. 1 60** to **Oct. 17-60** and last saw her <sup>her</sup> alive on **Feb. 8 60**  
Death occurred at **3:30 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>George L. Sawyer MD</i> (Degree or title)	22b. ADDRESS <b>1630 Professional Bldg.</b>	22c. DATE SIGNED <b>10/18/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
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24. FUNERAL DIRECTOR <b>Simmons Funeral Home K.C.K.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-19-60</b>	26. REGISTRAR'S SIGNATURE <i>H. L. Sawyer</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

4-1-1961

DEC 8 1961

**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 Donner K. James

Licensed Embalmer No. 482

P. O. Address K.C.

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