

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

5635-60-041889
5635

FILED VS DEC 5 1960 149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 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 COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 49 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 St Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 805 Bennington Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MAY Middle AGNES Last BROOKS			4. DATE OF DEATH Month November Day 7 Year 1960	
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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 10/27/1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) South Haven Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Luther F Baugh	13b. MOTHER'S MAIDEN NAME Ann Harris	14. NAME OF HUSBAND OR WIFE Fred S Brooks
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Fred S Brooks	Address 805 Bennington K C Mo
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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: IMMEDIATE CAUSE (a) Cerebral Anoxia		INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Myocardial Insufficiency	2 days
	DUE TO (c) Arteriosclerotic Heart Disease	8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cirrhosis of Liver	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
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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 Month, Day, Year a.m. p.m.

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
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21. I attended the deceased from January 1960 to present and last saw her/him alive on 11-7-60 Death occurred at 3:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE George K. Bond (Degree or title)	22b. ADDRESS 5111 Independence Ave K.C. Mo	22c. DATE SIGNED 11-8-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/10/60	23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cem	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo ADDRESS	25. DATE RECD. BY LOCAL REG. 11-9-60	26. REGISTRAR'S SIGNATURE H-L. Dwyer
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF George K. Bond

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.