

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042165

FILED VS DEC 1 2 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5811

IDED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>9 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home Gray Norte Nursing</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>217 E. Linwood</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>60</u>				
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-29-1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and state or country) <u>Corning, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Gus McPherrin</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>			14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Verda Blair 217 E. Linwood KCMO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Fracture of femur</u> DUE TO (c) <u>Femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not included in the terminal disease condition given in PART I (a) <u>Swelled Pneumonia after fall</u> 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							INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>fall in a nursing home</u>						
20c. TIME OF INJURY Hour <u>10-30</u> Month, Day, Year <u>home</u>	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.) <u>nursing home</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		COUNTY <u>Jackson</u>	STATE <u>MO</u>		
21. I attended the deceased from _____ to _____ and last saw her/him _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Usual or title) <u>Melody McGilley-Eylar</u>				22b. ADDRESS <u>Linwood 20 W.</u>		22c. DATE SIGNED <u>11-16-60</u>		
23a. FUNERAL, CREMATION, OR REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>11-16-60</u>	<u>Memorial Park</u>		<u>Kansas City Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar 20 W. Linwood</u>				25. DATE RECD. BY LOCAL REG. <u>11-8-60</u>		26. REGISTRAR'S SIGNATURE <u>H-L Owyer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Hugh H. OWENS

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 Wm H. Lentz

Licensed Embalmer No. 5038

P. O. Address K. C. G. M.

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

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