

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042398

FILED VS DEC 6 1960 /46

3026

568

STATE FILE NUMBER

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

UNDED

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 Independence		Length of stay in 1b 74 yrs.		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Rest Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 11104 E. 24th. St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Josie Middle M. Last Saunders				4. DATE OF DEATH Month Nov. Day 29 Year 1960					
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6/27/1866	9. AGE (last birthday) 94	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 --		11. BIRTHPLACE (City and state or country) Schoharie County, N.Y.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME James Gurnsey			13b. MOTHER'S MAIDEN NAME Ada Stevens			14. NAME OF HUSBAND OR WIFE Joseph N. Saunders			
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. ---		17. INFORMANT Ada Belle Jackson Address 11104 E. 24th St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility							INTERVAL BETWEEN ONSET AND DEATH 8 1/2 wks		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____							
		DUE TO (c) fracture Rt femur							
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 1956 to 11-29-60 and last saw her/him alive on 11-25-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE J. Saunders (Degree or title)				22b. ADDRESS Independence				22c. DATE SIGNED 11-30-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Dec. 2, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery			23d. LOCATION (City, town, or county) (State) Kansas City, Missouri			
24. FUNERAL DIRECTOR Earp & Sons		ADDRESS 4707 Truman Rd. K.C.Mo.		25. DATE RECD. BY LOCAL REG. 12-2-60		26. REGISTRAR'S SIGNATURE James Craig			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 William H. Eng

Licensed Embalmer No. 4728

P. O. Address N. C. N.

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