

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

-60-046030

5916

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1602 Registrar's No.

DED

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|---|---|---|--|--|---------------------------|--|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <i>Jackson</i> | | b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i> | | a. STATE <i>Missouri</i> | | b. COUNTY <i>Jackson</i> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Joseph Hosp</i> | | Length of stay in 1b <i>Life</i> | | c. CITY OR TOWN <i>Kansas City</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First <i>Bertram</i> | | Middle <i>E</i> | | Last <i>Edwards</i> | |
| 4. DATE OF DEATH | | Month <i>Nov</i> | | Day <i>25</i> | | Year <i>1960</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 30, 1893</i> | 9. AGE (last birthday) <i>77</i> | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 24 HR Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman & Manager</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Film Dist. Co</i> | | 11. BIRTHPLACE (City and state or country) <i>Kansas City, Mo</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A</i> | |
| 13a. FATHER'S NAME <i>Noel Edwards</i> | | 13b. MOTHER'S MAIDEN NAME <i>Catherine Reynolds</i> | | 14. NAME OF HUSBAND OR WIFE <i>Inez Edwards</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>Dorothy Edwards</i> | | Address <i>1864 E 76 Terr</i> | |
| 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) <i>Uremia</i> | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO (b) <i>Carcinoma of Bladder</i> | | | | | | | |
| 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 s.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 | |
| 21. I attended the deceased from <i>Mar 5, 1960</i> to <i>death</i> and last saw her/him alive on <i>11-25-60</i> Death occurred at <i>9 AM</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>Wm E. Mc Millan</i> | | | | 22b. ADDRESS <i>1819 Prof. Bldg Kansas City Mo</i> | | 22c. DATE SIGNED <i>11-25-60</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Nov 28, 1960</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Floral Hills</i> | | 23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo.</i> | |
| 24. FUNERAL DIRECTOR <i>Muehlebach</i> | | ADDRESS <i>6800 Troost</i> | | 25. DATE RECD. BY LOCAL REG. <i>11-25-60</i> | | 26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i> | |

DOCUMENT

BY AFFIDAVIT OF *Wm E. Mc Millan* MEDICAL CERTIFICATION

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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address H. C. Mc

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.