

RIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046211
STATE FILE NUMBER

FILED VS DEC 8 1960 149 Primary Registration District No. 1002 Registrar's No. 6173

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| 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 Kansas City, | | Length of stay in 1b 40 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 3340 South Benton | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3340 South Benton | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mattie Middle Betty Last Martin | | | | 4. DATE OF DEATH Month Dec. Day 7, Year 1960 | | | | |
| 5. SEX female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 10-3-98 | 9. AGE (last birthday) 62 | 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) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Private Family | | 11. BIRTHPLACE (City and state or country) Springer, Okla. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Thomas Hancock | | | 13b. MOTHER'S MAIDEN NAME Dora Mason | | 14. NAME OF HUSBAND OR WIFE Herman Martin | | | |
| 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 Address Victoria Martin, K. C. Mo. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 Mi. | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Lymphatic Leukemia, Splenic | | | | | | 2 Yr.s | | |
| 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 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 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 | | |
| 21. I attended the deceased from Oct 15, 1960 to Dec. 7, 1960 and last saw her/him alive on Dec. 7, 1960 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Emmett F. Walls | | | | 22b. ADDRESS 2628 Troost | | 22c. DATE SIGNED 12-8-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-10-60 | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | | | |
| 24. FUNERAL DIRECTOR ADDRESS Mrs. Meek's Mortuary, K. C. Mo. | | | 25. DATE RECD. BY LOCAL REG. 12-8-60 | | 26. REGISTRAR'S SIGNATURE H-S-Dwyer | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Emmett F. Walls

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 Millard B. P.

Licensed Embalmer No. 50

P. O. Address K. C.

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.