

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046255
STATE FILE NUMBER

FILED VS DEC 19 1960

149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

6025

INDEXED

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY			Length of stay in 1b 1 YEAR		c. CITY OR TOWN OVERLAND PARK		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6701 WEST 76TH STREET	
3. NAME OF DECEASED (Type or print) First Frieda Middle CHRISTINA Last Oglesby				4. DATE OF DEATH Month NOVEMBER Day 30 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 3/3/1897	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (City and state or country) PEORIA, ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JOHN BOHI			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE RICHARD JAMES OGLESBY, SR.	
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 THOMAS J. OGLESBY Address 6701 WEST 76TH STREET OVERLAND PARK, KANSAS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Auricular Fibrillation, Acute DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pre-Invasive Carcinoma Cervix PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs							
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 July 1960 to Nov 30, 1960 and last saw her alive on Nov 30, 1960 Death occurred at 11th AM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Charles R. Knox M.D.</i>				22b. ADDRESS 1412 30 Rivalts Bldg. F.C. Mo		22c. DATE SIGNED 11-30-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE NOV. 30, 1960		23c. NAME OF CEMETERY OR CREMATOR ----		23d. LOCATION (City, town, or county) (State) PEORIA ILLINOIS	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. 12-1-60		26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Charles R. Knox

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 James W. Steg

Licensed Embalmer No. 3780

P. O. Address A. C. 7

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.