

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26339  
Registrar's No. 3370

FILED SEP 4 1948

Registration District No. 149

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lakeside Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
In this community as above (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Marie Hallan

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Earl Hallan

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased 9-22-1891  
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business X

12. Name Softus Cervila

13. Birthplace Indian  
(City, town, or county) (State or foreign country)

14. Maiden name Ann Houdeshell

15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Hallan

(b) Address Iola, Kansas

17. (a) removal (b) Date thereof 8-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Iola, Kansas

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 8-18-48 (b) Geraldine Holms  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Allen 994

(c) City or town Iola 14  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 2

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country \_\_\_\_\_ X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18  
year 1948 hour 3:03 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Aug. 11, 1948 to 8-18, 1948  
that I last saw her alive on 8-18, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac posterior myocardial infarct 4 days  
Due to arteriosclerosis  
Electrocardiography showed also fatty infiltration of myocardium & coronary sclerosis.  
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Very fibrous uterus  
Of operations partial hysterectomy  
Of autopsy pathology of cardiac muscle 56 lb

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature J. J. Graham (M. D. or other) MD  
Address 418 Bryant Bldg Date signed 8-18-48

Dr. Graham - Dr. ~~Wilcox~~ Leonard,  
518 Argyle Bldg., at Lakeville

OCT 25 1948

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Charles H. Stickney

Licensed Embalmer No. 45600

P. O. Address K.E. Inc.

**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 this body is not embalmed, fact should be so stated above.**