

THE DIVISION OF HEALTH OF MISSOURI
FILED MAR 22 1949 STANDARD CERTIFICATE OF DEATH8322
State File No. 876

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>876</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) township) <u>1</u> <u>2</u> <u>YEARS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		4Y 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5834 PARK AVENUE</u>				d. STREET ADDRESS (If rural, give location) <u>5834 PARK AVENUE</u>			
3. NAME OF DECEASED (Type or Print) <u>BESSIE LEE</u>		a. (First) <u>AMES</u>		b. (Middle) <u>COLLINS</u>		c. (Last)	
4. DATE OF DEATH <u>FEB-23-1949</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED 1</u>	
8. DATE OF BIRTH <u>AUG-3-1890</u>		9. AGE (In years last birthday) <u>58</u> YRS		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER OF ALTERATIONS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KLINES DEPT. STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ARCHIE L. HANKESON</u>		13b. MOTHER'S MAIDEN NAME <u>ESTHER L. E. BLODGETT</u>	
14. NAME OF HUSBAND OR WIFE <u>CHARLES T. COLLINS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-05-0912</u>		17. INFORMANT'S SIGNATURE OR NAME <u>CHARLES T. COLLINS</u> ADDRESS <u>5834 PARK AVENUE KANSAS CITY, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Central embolism aorta</u> ? INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Central arteriosclerosis</u> ? DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>334X</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20</u> , 19 <u>44</u> , to <u>2/23</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>49</u> and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C. G. Leatch</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>1109 Pryor Bldg.</u>		23c. DATE SIGNED <u>2/24/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB. 25-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>2-25-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Newcomer's Sons</u> ADDRESS <u>1401 BRUSH GREEN Bldg. KANSAS CITY, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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-----

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

W. P. Nofsinger

Licensed Embalmer No. *5938*

P. O. Address *Spokane City, W.*

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.