

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

No. 300 10.48		FILED MAR 16 1949		THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH		State File No. 8725	
BIRTH NO.		REG. DIST. NO. 146		PRIMARY REG. DIST. NO. 3026		Registrar's No. 86	
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, write RURAL and give township) Independence		c. LENGTH OF STAY (In this place) U		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Rural			
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitorium				d. STREET ADDRESS (If rural, give location) 8710 Thompson (Blue)			
3. NAME OF DECEASED (Type or Print)		a. (First) Edward		b. (Middle) Ray		c. (Last) Monath	
5. SEX Male		6. COLOR OR RACE Wh		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 9/26/1916	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unemp.		11. BIRTHPLACE (State or foreign country) Indianapolis, Ind.		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Clarence Monath		13b. MOTHER'S MAIDEN NAME Blanche Maffitt		14. NAME OF HUSBAND OR WIFE Nancy Johnson Monath			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 487-0702338		17. INFORMANT'S SIGNATURE OR NAME Nancy Monath		ADDRESS 8710 Thompson	
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) Shock ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Skull Fracture DUE TO (c) Motor cycle Trauma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C. 8/12/4				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Deputy Coroner				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, store, etc.) 15th Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 2 5 49		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell on Cycle			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE A. Ellsper				23b. ADDRESS 2800 Main		23c. DATE SIGNED 3/17/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/10/49		24c. NAME OF CEMETERY OR CREMATORY Mt. Washington		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. Mar. 8-4-49		REGISTRAR'S SIGNATURE Alma A. Baker		FUNERAL DIRECTOR'S SIGNATURE W. B. Smith		ADDRESS Kansas City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

AUG 22 1949

JUN 28 1957

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

John P. Shick

Licensed Embalmer No. 3625

P. O. Address K. G. M.

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.