

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19576

State File No.

2834

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>		d. STREET ADDRESS (If rural, give location) 1307 Bennington	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1307 Bennington home			

3. NAME OF DECEASED (Type or Print) a. (First) Cora	b. (Middle) May	c. (Last) Helard	4. DATE OF DEATH (Month) (Day) (Year) 6/30/49
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5. SEX Fem / Wh	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid	8. DATE OF BIRTH 4/10/1878	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Ohio /	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME John Steffee	13b. MOTHER'S MAIDEN NAME Delia Hunt	14. NAME OF HUSBAND OR WIFE George Helard
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Bessie Johnson, 1307 Bennington	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4201
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion?		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Beer & treated for Heart			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Autopsy Refused	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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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 Hugh H. Owens (Degree or title)	23b. ADDRESS 1034 Pratts Blde	23c. DATE SIGNED 7-1-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/2/49	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 7-1-49	REGISTRAR'S SIGNATURE Sheldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil, Kansas City, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Railto Bldg.
After 2 P M 7/1/49

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.

Signed John P. Shud

Signed _____
Student Embalmer

Licensed Embalmer No. 3625

P. O. Address 66 2nd

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.