

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19737

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001 Registrar's No. 2203

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) OR TOWN Kansas City Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3215 Campbell Street		d. STREET ADDRESS (If rural, give location) 3215 Campbell Street	

3. NAME OF DECEASED (Type or Print) Mr Edwin D. PRIEST			4. DATE OF DEATH (Month) (Day) (Year) June 21 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Months Days 78	10. UNDER 14 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown	
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary's Rest Home 3215 Campbell St	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION H2^r		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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) m.		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 July 1947, to June 21, 1949, that I last saw the deceased alive on June 16, 1949, and that death occurred at 3:30 AM., from the causes and on the date stated above.

23a. SIGNATURE Gertrude Stevens <i>Gertrude Stevens</i>		23b. ADDRESS 1103 E. Arroyo		23c. DATE SIGNED 6-21-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-22-49		24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem	
24d. LOCATION (City, town, or county) (State) Kansas City Kansas		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS France-Wornall Funeral Ho			
DATE REC'D BY LOCAL REG. 6-22-49		REGISTRAR'S SIGNATURE Theraldine Holmes			

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.

Signed.....

Russell N. France

Signed.....
Student Embalmer

Licensed Embalmer No.

4255

P. O. Address.....

K. O. 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.