

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23651
2972

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 Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City	c. LENGTH OF STAY (in this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6515 Prospect		d. STREET ADDRESS (If rural, give location) 6515 Prospect	

3. NAME OF DECEASED (Type or Print) a. (First) BESSIE		b. (Middle)		c. (Last) SOUDERS		4. DATE OF DEATH (Month) (Day) (Year) 7 7 49		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 8-22-1880		9. AGE (in years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY XX		11. BIRTHPLACE (State or foreign country) Kansas City Mo. D		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Husted M. Evans		13b. MOTHER'S MAIDEN NAME No Record		14. NAME OF HUSBAND OR WIFE Harley H. Souders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) XX	17. INFORMANT'S SIGNATURE OR NAME Harley H. Souders		ADDRESS 5821 Michigan	

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				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolus		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Phlebotrombosis left knee leg				One day
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis + Cerebral sclerosis		DUE TO (c)				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 463X				20. AUTOPSY? YES <input checked="" 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)		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 Jan 10, 1948, to July 7, 1949, that I last saw the deceased alive on July 7, 1949, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE W. Parker, Jr. (Degree or title)		23b. ADDRESS 2603 E 31st St., K.C. Mo.		23c. DATE SIGNED 7-8-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-9-49	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington		24d. LOCATION (City, town, or county) (State) Kansas City Mo.	

DATE REC'D BY LOCAL REG. 7-8-49	REGISTRAR'S SIGNATURE Sheraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Wagner - K.C. Mo.		
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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 Alvin R. Haunse

Signed.....
Student Embalmer

Licensed Embalmer No. 4159

P. O. Address Kansas Ci

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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