

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43815

State File No. ....

5478

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>5478</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 town) <u>Kansas City,</u>			c. LENGTH OF STAY (in this place) <u>5 yrs.</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4121 Charlotte</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Margaret</u>		b. (Middle) <u>R</u>		c. (Last) <u>Walmer</u>	
4. DATE OF DEATH <u>December 24 '49</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>Nov. 1, 1910</u>		9. AGE (In years last birthday) <u>39</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chapman Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Leavenworth, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Vandergriff</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Ann Schloo</u>		14. NAME OF HUSBAND OR WIFE <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>511-03-4577</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Russell E. Baker</u>		ADDRESS <u>7625 Conser,</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>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic nephritis</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>  <u>unknown</u>  <u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>592</u>				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) 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 _____, 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 <u>William F. Sanders</u> (Degree or title) <u>William F. Sanders M.D. (Anatomologist)</u>				23b. ADDRESS <u>Research Hospital</u> <u>Kansas City, Mo.</u>		23c. DATE SIGNED <u>12/27/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12/27/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Leavenworth Kansas.</u>	
DATE REC'D BY LOCAL REG. <u>12-27-49</u>		REGISTRAR'S SIGNATURE <u>Maldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Melody-McGilley-Eylar</u>		ADDRESS <u>K. C., Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48

3008

**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 Max W. Kirkendall

Signed.....  
Student Embalmer

Licensed Embalmer No. 4632

P. O. Address F. G. Mo

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.