

FILED APR 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8734
1264

| | | | | | | | |
|---|---------------------------|--|--|---|---|---|---|
| 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) 38 YEARS | | c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY | | d. STREET ADDRESS (If rural, give location) 1315 VALENTINE ROAD | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION LINWOOD NURSING HOME 1900 LINWOOD BLVD | | | | d. STREET ADDRESS (If rural, give location) 1315 VALENTINE ROAD | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) KATIE | | | b. (Middle) MAY | | c. (Last) HINDS | | 4. DATE OF DEATH (Month) (Day) (Year) MAR. 14-1950 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED | 8. DATE OF BIRTH SEPT-23-1865 | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months | IF UNDER 1 HR. Days | IF UNDER 1 MIN. 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 --- | | 11. BIRTHPLACE (State or foreign country) ROCKPORT INDIANA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME ISAAC SWALLOW | | 13b. MOTHER'S MAIDEN NAME MATILDA GASTON | | 14. NAME OF HUSBAND OR WIFE L.A. HINDS | | | |
| 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 MRS. EVA E. BROWN | | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 18 hrs. | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardio-Vasc. 3+ Yr. | | | | 3+ Yr. | |
| | | DUE TO (c) Arteriosclerosis, General | | | | 3+ 1/2 | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Old hemi-plegia. | | | | 1 1/2 Yr. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION None | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | | 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 19 49 to March 14 1950, that I last saw the deceased alive on Feb 7 19 50 and that death occurred at 2:45 P. m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Robt. J. Boddy | | | | 23b. ADDRESS 217 Flora Pine Bldg. MO | | 23c. DATE SIGNED 3/15/50 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE MAR. 17-1950 | 24c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY | | 24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI | | |
| DATE REC'D BY LOCAL REG. 3-17-50 | | REGISTRAR'S SIGNATURE Deraldine Holmes | | | 25. FUNERAL DIRECTOR'S SIGNATURE O. H. Newcomer | | |
| | | | | | ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO. | | |

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Wayne L. Daniel*

Signed.....
Student Embalmer

Licensed Embalmer No. *4702*

P. O. Address *Kansas City - 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.