

FILED MAY 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13318**
1798

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) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3121 GARFIELD		d. STREET ADDRESS (If rural, give location) 3121 GARFIELD	
3. NAME OF DECEASED (Type or Print) a. (First) MARTHA b. (Middle) _____ c. (Last) WALLACE		4. DATE OF DEATH (Month) (Day) (Year) APRIL 14, 1950	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (State or foreign country) MISSOURI
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT'S SIGNATURE OR NAME JACK SCHIFFMACHER		ADDRESS PROFESSIONAL BLDG.	
18. CAUSE OF DEATH Enter only one on separate line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complications which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Encephalomalacia (b) Cerebral Arteriosclerosis (c) Hypertensive Myocarditis	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		INTERVAL BETWEEN ONSET AND DEATH 4431	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on _____, 19____, from the causes and on the date stated above.			
23. SIGNATURE Russell W. Kerr (Degree or title)		23b. ADDRESS St. Joseph Hospital	
23c. DATE SIGNED 4/17/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	24b. DATE 4/17/50	24c. NAME OF CEMETERY OR CREMATORY ELMWOOD	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.	ADDRESS K. C., MO.		

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

3008

540

1911
12300A

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.

Student _____
Student Embalmer

Signed S. J. Allen

Licensed Embalmer No. 1412

P. O. Address H. C. M. S.

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.