

FILED AUG 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27111  
3289

|   |  |   |                      |  |  |  |  |  |  |
|---|--|---|----------------------|--|--|--|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. 149  |                      | PRIMARY REG. DIST. NO. 1002  |  | Registrar's No. _____  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |  |   |                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Jackson  |  |  |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City  |  | c. LENGTH OF STAY (in this place) 6 days  |                      | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City   |  | d. STREET ADDRESS (If rural, give location) 3348                                 |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital   |  |   |                      | d. STREET ADDRESS (If rural, give location) 3348   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) ALICE   |  |   | b. (Middle) SCRIVNER |  |  | c. (Last) SCRIVNER   |  |  |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br>July 31-1950   |  | 5. SEX Female   |                      | 6. COLOR OR RACE White   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed                   |  |  |  |
| 8. DATE OF BIRTH 11-22-1876   |  | 9. AGE (In years last birthday) 73  |                      | 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) Jefferson City Mo   |  | 12. CITIZEN OF WHAT COUNTRY? USA  |                      | 13a. FATHER'S NAME Garland Johnson   |  | 13b. MOTHER'S MAIDEN NAME Rebecca Lester   |  |  |  |
| 14. NAME OF HUSBAND OR WIFE Charlie Scrivner  |  | 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 AND ADDRESS Draver E. Lutz, Kansas City        |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Arteriosclerosis & Myocardial Degeneration<br>DUE TO (c) Fracture R hip<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>Several days<br>1201<br>6 days |  |
| 19a. DATE OF OPERATION 7-27-50  |  | 19b. MAJOR FINDINGS OF OPERATION Hip railing  |                      |  |  | 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 7-27-50, 10, to 7-31, 1950, that I last saw the deceased alive on 7-31, 1950, and that death occurred at 9:30 A. m., from the causes and on the date stated above.       |  |   |                      |  |  |  |  |  |  |
| 23a. SIGNATURE Frank B. Lutz, M.D. (Degree or title) Frank B. Lutz, M.D.  |  |   |                      | 23b. ADDRESS 1530 Prof. Bldg, Kansas City, Mo  |  | 23c. DATE SIGNED 8-1-50  |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 24b. DATE Aug 2-50  |                      | 24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill   |  | 24d. LOCATION (City, town, or county) (State) Jefferson City, Mo                 |  |  |  |
| DATE REC'D BY LOCAL REG. 8-1-50   |  | REGISTRAR'S SIGNATURE Geraldine Helmer  |                      | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W. Steppes, Research Hospital   |  |  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

*G. S. Steffens*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *2307*

P. O. Address *Russellville*

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.