

FILED OCT 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33640**
4355

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 4355	
1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Carroll			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo		c. LENGTH OF STAY (In this place) 1 yr.		c. CITY (If outside corporate limits, write RURAL and give township) Boyard, Mo		d. STREET ADDRESS (If rural, give location) city 0170	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3104 Brooklyn				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Ann b. (Middle) Elizabeth c. (Last) Musser			4. DATE OF DEATH (Month) (Day) (Year) 10-14-50				
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH June 1-1879	
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most working hrs. even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME James Wilson			13b. MOTHER'S MAIDEN NAME Colona Brundige			14. NAME OF HUSBAND OR WIFE Dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME Leslie Musser			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Metastatic Cancer in brain ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Carcinoma st. eat DUE TO (c) Cachexia				INTERVAL BETWEEN ONSET AND DEATH 6 mos. 4 1/2 yrs. 191X 6 mos.	
19a. DATE OF OPERATION Mar. 2 1949		19b. MAJOR FINDINGS OF OPERATION Epidermoid Carcinoma st. eat				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 Oct 28, 1946 , to Oct 13, 1950 , that I last saw the deceased alive on Oct 13, 1950 , and that death occurred at 8 A. m. , from the causes and on the date stated above.							
23a. SIGNATURE E. Kip Robinson MD.				23b. ADDRESS 928 Holmes Bldg. K.C. Mo.		23c. DATE SIGNED Oct. 14 '50	
24a. BURIAL, CREMATION (REMOVAL) (Specify)		24b. DATE burial Oct 15-50		24c. NAME OF CEMETERY OR CREMATORY Colona		24d. LOCATION (City, town, or county) (State) Colona Mo.	
DATE REC'D BY LOCAL REG. 10-14-50		REGISTRAR'S SIGNATURE Heraldine Holmes			25. FUNERAL DIRECTOR'S SIGNATURE E.A. Decker		
					ADDRESS Boyard, 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.....

E. A. Dickerson

Signed.....
Student Embalmer

Licensed Embalmer No..... *2534*

P. O. Address..... *Bogard*

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.