

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37052

State File No.

FILED DEC 9 1950

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1602 Registrar's No. 4966

008

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

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 township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>3 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>3609 East 60th Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3609 East 60th Street</u>			

790

3. NAME OF DECEASED (Type or Print) a. (First) <u>FLORENCE</u> b. (Middle) <u>S.</u> c. (Last) <u>HARMS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 24, 1950</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 10, 1873</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Peter W. Shick</u>		13b. MOTHER'S MAIDEN NAME <u>Whitman</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME MO. ADDRESS <u>Mrs. John D. Valentine, 3609 E. 60th St., K.C.</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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 year</u> <u>33 1/2</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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 Feb 1, 1950, to Nov. 24, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>John K. Caldwell</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>1036 Angyle Kansas City Mo</u>	23c. DATE SIGNED <u>11/25/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11/25-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>—</u>	24d. LOCATION (City, town, or county) (State) <u>Lawrenceville, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>11-25-50</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCLURE, Kansas City, Missouri</u>
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Dr. John K. Caldwell
Angyle, Bldg.
Ha. 2486

[Handwritten scribble]

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.....
Student Embalmer

Signed *Joseph M. McCarthy*
Licensed Embalmer No. *4694*

P. O. Address *H. B. 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.