

FILED MAR 3 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1940

731

BIRTH NO. 65940-50 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 Mo b. COUNTY Jackson	
b. CITY OR TOWN Kansas City		c. CITY OR TOWN Kansas	
c. LENGTH OF STAY (in this place) life		d. STREET ADDRESS (If rural, give location) 2211 Bales	
d. FULL NAME OF HOSPITAL OR INSTITUTION Metropolitan Hosp		229 3750	

3. NAME OF DECEASED (Type or Print) MARY TEETERS			4. DATE OF DEATH (Month) (Day) (Year) 2-15-51		
a. (First)	b. (Middle)		c. (Last)	Month	Day

5. SEX F	6. COLOR OR RACE WH	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 25, 1950	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Days 20	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City Mo		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Luther Teeter		13b. MOTHER'S MAIDEN NAME Oda Watkins		14. NAME OF HUSBAND OR WIFE	
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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 ADDRESS Oda Teeter 2211 Bales	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rabar Pneumonia		DUPLICATE		6 days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		490X	
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) 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 2/8 1951, to 2/14 1951, that I last saw the deceased alive on 2/14 1951, and that death occurred at 4:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE R.R. Tonkens (Degree or title) Dr. R.R. Tonkens D.O.		23b. ADDRESS Bryant Bldg 929		23c. DATE SIGNED 2/16/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 2-16-51		24c. NAME OF CEMETERY OR CREMATORY --		24d. LOCATION (City, town, or county) (State) Stewartville, Mo.	
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DATE REC'D BY LOCAL REG. 2-16-51		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Passantino Bros KC Mo	
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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.

Student

Student Embalmer

Signed

J. S. Malton

Licensed Embalmer No. *2744*

P. O. Address *K. C. 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.