

FILED MAR 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8524
8523

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 CLAY	
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 GASHLAND-RURAL 0240	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital		d. STREET ADDRESS (If rural, give location) R.R.#1	

3. NAME OF DECEASED (Type or Print) a. (First) OCTAVIA b. (Middle) ALDORPH c. (Last) HETZLER	4. DATE OF DEATH (Month) (Day) (Year) FEB-19-1951
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG-8-1902	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME	10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) CHICAGO ILLINOIS	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME LEROY T. WILCOX	13b. MOTHER'S MAIDEN NAME OCTAVIA FIELD'S	14. NAME OF HUSBAND OR WIFE CHARLES HETZLER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 486-07-6198	17. INFORMANT'S SIGNATURE OR NAME R.R.#1 ADDRESS CHARLES HETZLER GASHLAND MO.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema (b) acute myocardial Decompensation? (c) acute Glomerulo nephritis		1 Week 2 weeks
II. OTHER SIGNIFICANT CONDITIONS Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			590X

19a. DATE OF OPERATION X	19b. MAJOR FINDINGS OF OPERATION X	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) X	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) X
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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? X
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22. I hereby certify that I attended the deceased from 2-6-1951 to 2-19-1951, that I last saw the deceased alive on 2-18-1951, and that death occurred at 2:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE Frank E. Day M.D., 2	23b. ADDRESS 4314 E 9th, R.C. Mo	23c. DATE SIGNED 2-20-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 22 1951	24c. NAME OF CEMETERY OR CREMATORY WIT MORIAN CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 2-22-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE O.W. Newcomer's Sons	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

18. 0/62

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

Basil Honey

Licensed Embalmer No. *724*

P. O. Address *Cashland, Md*

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.