S. No. 300
v. 10.48

FILED AUG 18 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26984

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1602 Registrar's No. 3335

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital No. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 1811 E. 31 St.

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3. NAME OF DECEASED (Type or Print)
a. (First): Ida
b. (Middle):
c. (Last): Jamison

4. DATE OF DEATH (Month) 8 (Day) 1 (Year) 51

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 4-11- 1889
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: ---- Holmes
13b. MOTHER'S MAIDEN NAME: No Record
14. NAME OF HUSBAND OR WIFE: Robert Jamison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Maxine Gaugh, Redlands Cali.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4201

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 31, 1951, *to* August 1, 1951, *that I last saw the deceased alive on* August 1, 1951, *and that death occurred at* 12:25A *m., from the causes and on the date stated above.*

23a. SIGNATURE B.I. Burns (Degree or title): B.I. Burns, M.D.
23b. ADDRESS: 24th & Cherry
23c. DATE SIGNED: 8-2-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-4-1951
24c. NAME OF CEMETERY OR CREMATORY: Forest Hill
24d. LOCATION (City, town, or county) (State): Kansas City, Missouri

DATE REC'D BY LOCAL REG.: 8-4-51
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Mrs. C.L. Forster, Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Burkhead

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 Joe B. Yoder

Licensed Embalmer No. 4473

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.