

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26993

FILED AUG 18 1951

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3336

4

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City	c. LENGTH OF STAY (In this place) 50 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Linwood Nursing Home		d. STREET ADDRESS (If rural, give location) 1900 Linwood	

3548

3. NAME OF DECEASED (Type or Print) a. (First) Almieda	b. (Middle)	c. (Last) Joslin	4. DATE OF DEATH (Month) (Day) (Year) 8-3-51
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH March 20, 1867
9. AGE (In years last birthday) 85 84		10. KIND OF BUSINESS OR INDUSTRY Sweedish Masseur	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sweedish Masseur	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME George Ferguson	13b. MOTHER'S MAIDEN NAME Margaret Karnes	14. NAME OF HUSBAND OR WIFE Will Joslin	

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 Mrs. Grace Ambrose	ADDRESS 811 E. Armour
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3-4 da
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) -		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			420

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City Jackson Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21h. HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from **June 29, 1951**, to **7-9, 1951**, that I last saw the deceased alive on **7-9, 1951**, and that death occurred at **6:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE F. B. Wallace MD (Degree or title)	23b. ADDRESS 1215 Pearl Bldg	23c. DATE SIGNED 8-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-4-51	24c. NAME OF CEMETERY OR CREMATORY --	24d. LOCATION (City, town, or county) (State) Topeka, Kans.
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DATE REC'D BY LOCAL REG. 8-4-51	REGISTRAR'S SIGNATURE S. Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE D. W. Newcomer's Sons	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.
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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 *Bernard L. Horan* _____

Licensed Embalmer No. *4250* _____

P. O. Address *N. 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.