

FILED AUG 18 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27183
3258

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 JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (In this place) 4 YEARS		d. STREET ADDRESS (If rural, give location) 7139 WYANDOTTE STREET	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) CLARA	b. (Middle) E.	c. (Last) SIMONS	4. DATE OF DEATH (Month) (Day) (Year) JULY 28 1951
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JAN 29 1879	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) KANSAS CITY KANSAS	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME FRANK NELSON	13b. MOTHER'S MAIDEN NAME NELLIE	14. NAME OF HUSBAND OR WIFE JOSON EDWIN SIMONS SR.
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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. NOISE	17. INFORMANT'S SIGNATURE OR NAME MRS. NELLIE OWENS ADDRESS 7139 WYANDOTTE KANSAS CITY 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Cerephalomalacia		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Cerebral Thrombosis		
	DUE TO (c) Alzheimer's		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Angioplasty both lower Extremities	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Russell W. _____	22b. ADDRESS St. Joseph Hospital	22c. DATE SIGNED 28 July 51
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22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE JULY 30 1951	22c. NAME OF CEMETERY OR CREMATORY DIV. NEWCOMER'S JONS	22d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 7-30-51	REGISTRAR'S SIGNATURE Geraldine Holmes	23. FUNERAL DIRECTOR'S SIGNATURE W. Newcomer's Sons ADDRESS 1331-BRUSH CREEK KANSAS CITY 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..... *Bernard L. Horan*

Licensed Embalmer No. *4250*

P. O. Address..... *HO M*

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.