

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41809

State File No.

5302

DEC 26 1951

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		d. STREET ADDRESS (If rural, give location) <u>712 E. 8 St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Theresa</u> b. (Middle) _____ c. (Last) <u>Salmons</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 7 51</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED? WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>1-7-1949</u>		9. AGE (In years last birthday) <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert Salmons</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Jenkins</u>	
13c. NAME OF HUSBAND OR WIFE _____		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Thomas Ford</u>	
17. INFORMANT'S SIGNATURE OR NAME		17. ADDRESS <u>712 E 8th</u>		17. ADDRESS <u>K.C. Mo</u>	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pharyngeal diphtheria</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		DUE TO (b) <u>Acute cerebral congestion</u>		DUE TO (c) _____	
MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		DUE TO (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) (Min.) _____		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 Dec. 3, 1951 to Dec. 7, 1951, that I last saw the deceased alive on Dec. 7, 1951, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>E. H. Stratemeyer</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>24th & Cherry</u>		23c. DATE SIGNED <u>12-8-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-10-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt Washington</u>	
24d. LOCATION (City, town, or county) (State) <u>K.C. Mo</u>		24e. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Sheil</u>		24f. ADDRESS <u>K.C. Mo.</u>	

DATE REC'D BY LOCAL REG. <u>12-10-51</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Sheil</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	

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

Dr. Humming

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 _____

John P. Sheil

Licensed Embalmer No. 3625

P. O. Address H. C. Ma

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.