

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8477

State File No.

FILED MAR 29 1952

1228

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) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL # 2 HOSPITAL		d. STREET ADDRESS (If rural, give location) 1227 PARK AVE. K.C.MO.	
3. NAME OF DECEASED a. (First) AMON		b. (Middle) E.	
c. (Last) MAYNARD		4. DATE OF DEATH (Month) (Day) (Year) MAR. 12, 1952	
5. SEX M.	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH MAY 10, 1910
9. AGE (In years last birthday) 41		10. AGE (In years) IF UNDER 1 YEAR IF UNDER 2 WKS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY COOK	
11. BIRTHPLACE (State or foreign country) RED RIVER COUNTY TEX.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Henderson Maynard		13b. MOTHER'S MAIDEN NAME ANNIE SHELTON	
14. NAME OF HUSBAND OR WIFE (Deceased)			
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. 443-09-14626	
17. INFORMANT'S SIGNATURE OR NAME Henderson Maynard		K.C. MO. ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock & Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured aorta DUE TO (c) Arteriosclerosis II. 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	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		(STATE)	
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)		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?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 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.			
23a. SIGNATURE (Degree or title) Dr. J. Jones M.D.		23b. ADDRESS 1612 E 12 St	
23c. DATE SIGNED 3/11/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-15-52	
24c. NAME OF CEMETERY OR CREMATORY Paris Texas		24d. LOCATION (City, town, or county) (State) Paris, Texas	
DATE REC'D BY LOCAL REG. 3-15-52		REGISTRAR'S SIGNATURE Sheraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE I.F. Ramsey		ADDRESS 1918 TRUMAN RD. K.C.MO.	

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

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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *J. F. Ramsey A.B.*

Signed.....
Student Embalmer

Licensed Embalmer No. *4081*

P. O. Address *1819 E. Truax Rd. K.*

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.