

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24708

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3246

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	
c. LENGTH OF STAY (in this place) 3 Years		d. STREET ADDRESS (If rural, give location) 1463 E. 78 St. 3908	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			

3. NAME OF DECEASED (Type or Print)	a. (First) Abraham	b. (Middle) Lincoln	c. (Last) Utt	4. DATE OF DEATH (Month) 7 (Day) 16 (Year) 52
-------------------------------------	---------------------------	----------------------------	----------------------	--------------------------------------------------------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12-9-1861	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	Min.
--------------------	-------------------------------	----------------------------------------------------------------------	-----------------------------------	-------------------------------------------	------------------------	-----------------------	------

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

13a. FATHER'S NAME Henry Joseph Utt	13b. MOTHER'S MAIDEN NAME Martha J. Slusher	14. NAME OF HUSBAND OR WIFE *****
--------------------------------------------	----------------------------------------------------	------------------------------------------

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. Frank Keith, 1463 East 78th. Street	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		
	ANTECEDENT CAUSES As forbid 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.		4201	

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)	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 July 8, 1952, to July 16, 1952, that I last saw the deceased alive on July 16, 1952, and that death occurred at 12:05A m., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns, M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 7-16-52
-----------------------------------------	---------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-17-1952	24c. NAME OF CEMETERY OR CREMATORY Elmwood	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
---------------------------------------------------------	----------------------------	---------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 7-17-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. C.L. Forster, Kansas City, Missouri.
-----------------------------------------	-----------------------------------------------	-------------------------------------------------------------------------------------------

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

Dr. Kerlan

43 12 1941

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. Under

Licensed Embalmer No. *4173*

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.