

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4014**

FILED SEP 27 1952

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City E3</b> "Rural" <sup>0470</sup>	
c. LENGTH OF STAY (on this place) <b>8 mo.</b>		d. STREET ADDRESS (If rural, give location) <b>922 Glenwood</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2905 Campbell Campbell Nursing</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Aimee</b>	b. (Middle) <b>Whitman</b>	c. (Last) <b>Hawthorne</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 9, 1952</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH <b>Mar. 13, 1876</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Rome, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>George Whitman</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Van Buskirk</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel C. Hawthorne</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Samuel C. R. Hawthorne, Jr.</b>	ADDRESS <b>922 Glenwood</b>
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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 <b>20 min.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Cardiac dilatation</b>		6 months
	ANTECEDENT CAUSES DUE TO (b) <b>Carcinoma of Stomach</b>		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		151X	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Senile deterioration</b>		3 years	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	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 June 15, 1951, to Sept 9, 1952, that I last saw the deceased alive on Aug 17, 1952, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Herbert Shuey</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>3903 Brooklyn</b>	23c. DATE SIGNED <b>9-10-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>9-10-52</b>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <b>Arcadia, Nebraska</b>
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DATE REC'D BY LOCAL REG. <b>9-11-52</b>	REGISTRAR'S SIGNATURE <b>Geraldine Holmes</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE UND. CO.</b>	ADDRESS <b>KANSAS CITY, MO.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Herbert Shuey  
3903 Brooklyn  
Wa 2493

cc: Mr. Shuey

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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 George Trammell  
Licensed Embalmer No. 4425-

P. O. Address H. C. 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.