

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4894**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 270

1. PLACE OF DEATH
a. COUNTY Duchanan
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Joseph
c. LENGTH OF STAY (In this place) 142-722 2 1/2
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph State Hosp. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City 7009
d. STREET ADDRESS (If rural, give location) Jackson County Home

3. NAME OF DECEASED
a. (First) Ethel b. (Middle) Mae c. (Last) Jamieson
4. DATE OF DEATH (Month) (Day) (Year) Feb 22-1953

5. SEX Female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow 8. DATE OF BIRTH June 26 1891
9. AGE (In years last birthday) Months Days 61 7 26

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) Oklahoma 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Robert Parker 13b. MOTHER'S MAIDEN NAME Suella Palter 14. NAME OF HUSBAND OR WIFE John A Jamieson

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 ADDRESS James M. Mock Overland Park 7330 N 74

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Influenza
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 480X

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Feb 17, 1953, to Feb 22, 1953, that I last saw the deceased alive on Feb 22, 1953, and that death occurred at 3:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE Forrest Thomas M.D. (Degree or title) 23b. ADDRESS St Joseph Mo of State Hosp No 2 23c. DATE SIGNED 2/22 53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 2/23/53 24c. NAME OF CEMETERY OR CREMATORY _____ 24d. LOCATION (City, town, or county) (State) Kansas City, Kansas

DATE REC'D BY LOCAL REG. March 3, 1953 REGISTRAR'S SIGNATURE Carl C. Casper 444 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Essie Clark 120 Minnesota

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Emmanuel*.....

Signed.....
Student Embalmer

Licensed Embalmer No. 4238.....

P. O. Address St. Joseph 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.