No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6478

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 57

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Prairie
c. LENGTH OF STAY (in this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jackson County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 3008
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): —
c. (Last): George

4. DATE OF DEATH (Month) (Day) (Year): Feb. 21, 1953

5. SEX: male 0
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown 9
8. DATE OF BIRTH: unknown
9. AGE (In years last birthday): — 9 — 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): unknown
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): unknown — 9
12. CITIZEN OF WHAT COUNTRY? — 9 —

13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
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): unknown
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S SIGNATURE OR NAME: Jackson Co Hosp Indep
ADDRESS: Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Valvular Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 4214

INTERVAL BETWEEN ONSET AND DEATH

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) m.
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* 4-1-52, 19__ *to* 2-21-53, 19__, *that I last saw the deceased alive on* 2-21-53, 19__, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. Suarez-Reyna 0 (Degree or title): M.D.
23b. ADDRESS: 1032 Prof. Bldg. K.C. Mo.
23c. DATE SIGNED: 2/28/53

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

DATE REC'D BY LOCAL REG.: 2-23-53
REGISTRAR'S SIGNATURE: N B Langsford 483
25. FUNERAL DIRECTOR'S SIGNATURE: N B Langsford
ADDRESS: Lee's Summit Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 B. J. Lindley

Licensed Embalmer No. 4822

P. O. Address Lake Summit

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.