

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572

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) Rural Prairie		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City 3438	
c. LENGTH OF STAY (in this place) 3 mons.		d. STREET ADDRESS (If rural, give location) 3009 Harrison 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital			
3. NAME OF DECEASED (Type or Print) Dorothy		4. DATE OF DEATH (Month) (Day) (Year) Feb. 13, 1953	
a. (First)		b. (Middle)	
c. (Last) Samuelson			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 24, 1889
9. AGE (In years less birthday) 63		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 2 HRS. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) Wessington Springs, S. Dak.	
12. CITIZEN OF WHAT COUNTRY?			
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)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Records of Jackson Co Hosp. Ind. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Valvular Heart Disease	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DUE TO (b) Marbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (c) 4214			
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 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)		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 11-13, 1952 , to 2-13, 1953 , that I last saw the deceased alive on 2-13, 1953 and that death occurred at 10:45 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Quay - Ryan M.D.		23b. ADDRESS 1032 Prop. Bldg.	
23c. DATE SIGNED 2/13/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-18-53	
24c. NAME OF CEMETERY OR CREMATORY Keis Summit		24d. LOCATION (City, town, or county) (State) Keis Summit Mo	
DATE REC'D BY LOCAL REG. 2-18-53		REGISTRAR'S SIGNATURE N.B. Langford 483	
25. FUNERAL DIRECTOR'S SIGNATURE N.B. Langford		ADDRESS Keis Summit Mo	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed B. J. Lindley
Licensed Embalmer No. 4822

P. O. Address Leeds 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.