

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18210

State File No. _____

FILED MAY 21 1953

2335

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>25 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>428 Wyoming</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Medical Center</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arthur</u> b. (Middle) <u>W</u> c. (Last) <u>Paine</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-5-53</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MARCH 3 1871</u>		9. AGE (In years last birthday) <u>82</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MHS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>INDEPENDENT ELEC.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>MADISON WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>DWIGHT FISKE PAINE</u>			13b. MOTHER'S MAIDEN NAME <u>MARY JANE ALFRED</u>		14. NAME OF HUSBAND OR WIFE <u>NANNIE B. PAINE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-16-2785</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS MARIE P. MORRIS HIGHLAND PARK, ILL</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Artery Sclerosis</u> <u>1 year</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>420</u>							
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 <u>5-1-53</u> to <u>5-5-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>5-4-53</u> , 19 <u>53</u> and that death occurred at <u>4:30</u> p.m. from the causes and on the date stated above.							
23a. SIGNATURE <u>Graham Asher</u> (Degree or title) <u>Graham Asher M.D. MD</u>				23b. ADDRESS <u>1220 N. 1st St. Kansas City, Mo. 64108</u>		23c. DATE SIGNED <u>5-5-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24b. DATE <u>MAY 7 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>5-5-53</u>		REGISTRAR'S SIGNATURE <u>Gertrude Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.W. Newcomer Sons 1331 BRUSH CREEK KANSAS CITY, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Robert Ray

Licensed Embalmer No. _____

4182

P. O. Address _____

Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.