

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21764**
2918
Registrar's No.

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 2918	
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 town) Kansas City		c. LENGTH OF STAY (In this place) 18 YEARS		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hospital				e. STREET ADDRESS (If rural, give location) 935 West 33rd. Street			
3. NAME OF DECEASED (Type or Print) a. (First) Ruth		b. (Middle) Cleveland		c. (Last) Thibau		4. DATE OF DEATH (Month) (Day) (Year) June 8 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 6, 1896	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and State or Foreign Country) MT. JEWETT, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME CLEVELAND		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE A.R. THIBAU			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME ADDRESS A. R. THIBAU 935 WEST 33RD ST. KANSAS CITY			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema and atelectasis ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) hydrothorax DUE TO (c) generalized carcinomatosis II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH 155+	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of the colon.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 _____, 19____, to _____, 19____, that I last saw the deceased <i>live on</i> HOLOG , 19____, and that death occurred at 9:00 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE Russell W. Kerr MD (Degree or title)				23b. ADDRESS St. Joseph Hospital, K. C. Mo.		23c. DATE SIGNED 6-9-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JUNE 10 1953		24c. NAME OF CEMETERY OR CREMATORY MT. MORIAM CEMETERY		24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
DATE REC'D BY LOCAL REG. 6-10-53		REGISTRAR'S SIGNATURE Shalline Smith		25. FUNERAL DIRECTOR'S SIGNATURE DW Taylor Sons - Kansas City Mo			

(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 Chester K Brown, Student Embalmer No. 476 working under my personal supervision..

Student Chester K Brown
Signature of Student Embalmer

Signed Edward M. Storey

Licensed Embalmer No. 445

P. O. Address K.C. 10 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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