

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24987**
Registrar's No. **3285**

FILED JUL 17 1953
BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY CLAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (in this place) 32 YRS.	c. CITY OR TOWN KANSAS CITY, MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKE HOSP.		e. STREET ADDRESS (If rural, give location) 3068 DIO 223 E. 43rd NORTH	
3. NAME OF DECEASED (Type or Print) MARTHA		a. (First) MARTHA b. (Middle) MAIN c. (Last) MAIN	4. DATE OF DEATH (Month) (Day) (Year) JUNE 26 1953
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 28 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 61
11. BIRTHPLACE (City and State or Foreign Country) Excelsior Springs, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Wade		13b. MOTHER'S MAIDEN NAME MARY MIDDLETON	14. NAME OF HUSBAND OR WIFE Gus P. MAIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gus P. MAIN 223 E 43rd ST. NORTH
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Both Lungs ANTECEDENT CAUSES Ca of Left Breast DUE TO (b) Ca of Left Breast DUE TO (c) _____ 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) m.		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 March 31, 1953 , to June 26, 1953 , that I last saw the deceased alive on June 26, 1953 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE George C. Lee (Degree or title) M.D.		23b. ADDRESS 1103 Grand Ave. K. C. Mo.	
23c. DATE SIGNED 6/27/53			
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE 6-29-53	
24c. NAME OF CEMETERY OR CREMATORY Crown Hill		24d. LOCATION (City, town, or county) (State) Excelsior Springs, MO	
DATE REC'D BY LOCAL REG. 6-29-53		REGISTRAR'S SIGNATURE Seraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Newcomer's N.K.C. MO.			

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. 483 working under my personal supervision..

Student John W. Kalbeck
Signature of Student Embalmer

Signed Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K. C. 16. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.