

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24999**
3158

No. 300
10-48

FILED JUL 17 1953

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

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 Missouri b. COUNTY RAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LEXINGTON MO 6490	
c. LENGTH OF STAY (in this place) 7 wks.		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp.			
3. NAME OF DECEASED a. (First) Mattie b. (Middle) Caroline c. (Last) Mavel		4. DATE OF DEATH (Month) (Day) (Year) June 21 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 1 1906
9. AGE (in years) last birthday 46		10. KIND OF BUSINESS OR INDUSTRY Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
13a. FATHER'S NAME William Keller		14. NAME OF HUSBAND OR WIFE Frank Mavel	
13b. MOTHER'S MAIDEN NAME Sarah J. Short		17. INFORMANT'S SIGNATURE OR NAME Frank Mavel Lexington Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		18. SOCIAL SECURITY NO. none	
16. MEDICAL CERTIFICATION		17. 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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Peritonitis	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Periarteritis nodosa	
		DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 738*	
19a. DATE OF OPERATION about May 20, 1953		19b. MAJOR FINDINGS OF OPERATION Biopsy of gastrocnemius muscle - perivascular inflammatory reaction	
21a. ACCIDENT SUICIDE HOMICIDE		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 May 7 , 19 53 , to June 21 , 19 53 , that I last saw the deceased alive on June 20, 1953 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
23a. SIGNATURE Frank Ferris M.D.		23b. ADDRESS 934 Maple St. Kansas City, Missouri	
23c. DATE SIGNED 6-21-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE June 21, 1953	
24c. NAME OF CEMETERY OR CREMATORY Lexington Mo.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 6-21-53		REGISTRAR'S SIGNATURE Geraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Stine & Mc Clure		ADDRESS Kansas City MO	

2436

202 3 24 4

Post-mortem

1924

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 _____

J. Crowell

Licensed Embalmer No. 4904

P. O. Address 920 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 this body is not embalmed, fact should be so stated above.