

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

25295

State File No. 289
 Registrar's No. 289

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Hickory	
b. CITY (If outside corporate limits, write RURAL, town, or town) OR TOWN Independence		c. CITY OR TOWN Hermitage	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence-San & Hosp.		e. STREET ADDRESS (If rural, give location) 0430	
3. NAME OF DECEASED (Type or Print) a. (First) Theresa		b. (Middle) I	
c. (Last) Geabhart		4. DATE OF DEATH (Month) (Day) (Year) July- 13-1953	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug-23-1885
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Topeka Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Smith		13b. MOTHER'S MAIDEN NAME Estella Pyles	
14. NAME OF HUSBAND OR WIFE Otis Geabhart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Otis Geabhart		ADDRESS Blue Springs Mo	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis 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 4201	
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 July 9, 1953, to July 11, 1953, that I last saw the deceased alive on July 13, 1953, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Fred Hink MD		23b. ADDRESS Kansas City - Mo	
23c. DATE SIGNED 7-15-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July-17-1953	
24c. NAME OF CEMETERY OR CREMATORY Mt Washington Cem		24d. LOCATION (City, town, or county) (State) Independence Mo	
DATE REC'D BY LOCAL REG. 7-16-53		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home		ADDRESS Blue Springs 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.....
Signature of Student Embalmer

Signed.....
R B Webb

Licensed Embalmer No. 235

P. O. Address Blue Spring

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.