

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28543

State File No. ....  
Registrar's No. **4012**

FILED AUG 27 1953

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 <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>Byrsmo</b>		e. STREET ADDRESS (If rural, give location) <b>IOI 1/2 East 26 St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Menorah Hospital</b>		3. NAME OF DECEASED (Type or Print) a. (First) <b>Jesse</b> b. (Middle) <b>Hartford</b> c. (Last) <b>Carney</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. II, 1953.</b>
8. DATE OF BIRTH <b>Mar. 22, 1885.</b>		9. AGE (In years last birthday) <b>68</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister Retired</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Lisbonville Mo.</b>
11. BIRTHPLACE (City and State or Foreign Country) <b>Lisbonville Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Samuel Carney</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Norton</b>	14. NAME OF HUSBAND OR WIFE <b>Winnie Carney</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Grace W. Clow IOI 1/2 East 26, K.C. Mo.</b>
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Peripheral Vascular Collapse</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Intestinal obstruction</b> DUE TO (c) <b>Fecolith</b> 11. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		5707	
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>Aug 8, 1953</u> , to <u>Aug 11, 1953</u> , that I last saw the deceased alive on <u>19 Aug, 1953</u> and that death occurred at <u>12:25A m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <b>W. Robinson</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>4635 W. Grand Ave. K.C. Mo.</b>	23c. DATE SIGNED <b>Aug. 11, 53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Aug. II, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Cashion</b>
24d. LOCATION (City, town, or county) (State) <b>Kingfisher Okla.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mrs. C.L. Forster Kansas City Mo.</b>	
DATE REC'D BY LOCAL REG. <b>8-12-53</b>		REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>	

Dr. Arthur Robinson  
4635 Wyandotte K.C. Mo.

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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 *Dean Owens*.....

Licensed Embalmer No. *428*.....

P. O. Address *K.C., 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.