

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **31991**
4348

BIRTH NO. **SEP 24 1953** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 40 yr	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City,		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3726 Fuller			d. STREET ADDRESS (If rural, give location) 59 3726 Fuller		

3. NAME OF DECEASED (Type or Print) a. (First) Mary Margaret		b. (Middle)		c. (Last) Schulling		4. DATE OF DEATH (Month) (Day) (Year) 9-3-1953			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 25-1885		9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Kansas City Mo. 0			12. CITIZEN OF WHAT COUNTRY? U S A		

13a. FATHER'S NAME Steven Haller		13b. MOTHER'S MAIDEN NAME Arminta Noland		14. NAME OF HUSBAND OR WIFE W.E.Schulling	
---	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS W.E.Schulling 3726 Fuller K.C.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.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Distention ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs 443X	
---	--	---	--	--	--	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input 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) (Min.)	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 **8/29**, 19**53**, to **9/3**, 19**53**, that I last saw the deceased alive on **8/29**, 19**53**, and that death occurred at **10 A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J.E. Ball M.D.		23b. ADDRESS 1102 E 47 N.C. MO		23c. DATE SIGNED 9/4/53	
--	--	---------------------------------------	--	--------------------------------	--

24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 9/5/1953	24c. NAME OF CEMETERY OR CREMATORY Holden	24d. LOCATION (City, town, or county) (State) Holden MO.		
---	---------------------------	--	---	--	--

DATE REC'D BY LOCAL REG. 9-4-53	REGISTRAR'S SIGNATURE Sheraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.B. Langford Lue's Summit 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
Student Embalmer

Signed *N. B. Langford*
Licensed Embalmer No. *3833*
P. O. Address *Leis Summit*

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.