

FILED OCT 23 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35990**
4750

BIRTH NO.		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 Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 45 years		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City 3468
d. FULL NAME OF HOSPITAL OR INSTITUTION Margaret Kathryn Nursing Home		d. STREET ADDRESS (If rural, give location) 1610 Valentine Road		
3. NAME OF DECEASED (Type or Print) MABEL PAULINE MEADER		a. (First)	b. (Middle)	c. (Last)
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 12, 1895	9. AGE (In years last birthday) 58 If under 1 year: Months Days If under 10 hrs: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Williams, Arizona	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James A. Ryan		13b. MOTHER'S MAIDEN NAME Mary Wills		14. NAME OF HUSBAND OR WIFE Frank R. Meader
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 Frank R. Meader, 1610 Valentine Rd., 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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalomalacia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days 6 weeks Indef.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Resection carcinoma sigmoid		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) 331X
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		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 6-30 , 19 53 , to 10-1 , 19 53 , that I last saw the deceased alive on 10-1 , 19 53 and that death occurred at 12:05 P.m. , from the causes and on the date stated above.				
23a. SIGNATURE E. G. Neighbor (Degree or title) <i>E. G. Neighbor, M.D.</i>		23b. ADDRESS 1420 S. 42nd KCK		23c. DATE SIGNED 10-2-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 3, 1953		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FREEMAN MORTUARY & CHAPEL, K.C., No.		
DATE REC'D BY LOCAL REG. 10-2-53		REGISTRAR'S SIGNATURE <i>Heraldine Smith</i>		

(Licensed Embalmer's Statement on Reverse Side)

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

11 - 5:50
FA-6060

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.