

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38988**
Registrar's No. **5504**

FILED DEC 10 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>1 year</u>		d. STREET ADDRESS (If rural, give location) <u>4009 Marcell</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>			

3. NAME OF DECEASED (Type or Print) KATHERINE CLOYES

a. (First) _____ b. (Middle) _____ c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) Nov-19-1953

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Sept. 17-1880 9. AGE (In years) (Months) (Days) (If under 1 year: Hours) (Mins.) 73

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 10b. KIND OF BUSINESS OR INDUSTRY Travel-Collin Co 11. BIRTHPLACE (City and State or Foreign Country) Chillicothe Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Maroney Jarrett 13b. MOTHER'S MAIDEN NAME Kate White 14. NAME OF HUSBAND OR WIFE Harry Cloyes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 486-09-8997 17. INFORMANT'S SIGNATURE OR NAME Mrs. Jane M. Jarrett ADDRESS 4009 Marcell St. Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES

* This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.

Due to (b) Viral Influenza 5 days

Due to (c) Fractured Pelvis 21 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Atherosclerosis 10 years

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) 12-3

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) OCT. 29, 1953 1:30 pm 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? Patient fell off back porch

22. I hereby certify that I attended the deceased from Oct 29, 1953, to Nov 19, 1953, that I last saw the deceased alive on Nov 18, 1953, and that death occurred at 7⁰⁰ a. m., from the causes and on the date stated above.

23a. SIGNATURE Robert L. Ward, M.D. (Degree or title) 23b. ADDRESS 3626 Indep. Ave. 23c. DATE SIGNED Nov 20, 1953

24a. BURIAL, CREMATION REMOVAL (Specify) Removal 24b. DATE Nov. 22-1953 24c. NAME OF CEMETERY OR CREMATORY Woodland Cem. 24d. LOCATION (City, town, or county) (State) Quincy, Illinois

DATE REC'D BY LOCAL REG. 11-21-53 REGISTRAR'S SIGNATURE Seraldine Smith 25. FUNERAL DIRECTOR'S SIGNATURE C.H. Blackburn ADDRESS 15. E. Mo.

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

1957
MAY 8 1957

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 W.C. Risse

Licensed Embalmer No. 4879

P. O. Address W.C. Risse

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.