

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **42759**  
**5818**

FILLED DEC 29 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
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 town) <u>Kansas City</u>			c. LENGTH OF STAY (in this place) <u>11 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN <u>Kansas City</u>			<u>3008</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Genia Hospr. #2</u>				d. STREET ADDRESS (If rural, give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Herman</u>		b. (Middle) _____		c. (Last) <u>Bean</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12-6-1953</u>	
5. SEX <u>2</u> <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 14, 1916</u>		9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Tableauah, Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Gus Bean</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Glass</u>		14. NAME OF HUSBAND OR WIFE <u>Iola Forman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1944-1946</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Iola Forman, 1213 E. 16th St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Pulmonary Edema</u>	ANTECEDENT CAUSES DUE TO (b) <u>Myocardial Insufficiency, Chronic adhesive Pericarditis, Hypertrophy of Thyroid gland</u>						
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) <u>Arteriosclerotic degeneration of cerebral vessels (left)</u>						
II. OTHER SIGNIFICANT CONDITIONS of <u>Essential state of cerebrum (left)</u>	Conditions contributing to the death but not related to the disease or condition causing death. <u>Emphysema, Luetic Arteritis (mild)</u>						<u>123X</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) _____		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>H. M. Tillman</u> (Degree or title) <u>Deputy Coroner, H. M. Tillman</u>				23b. ADDRESS <u>M. #3 1618 Lydia Ave</u>		23c. DATE SIGNED <u>12/8/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12/11/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Ft. Leavenworth, Kans.</u>	
DATE REC'D BY LOCAL REG. <u>12-11-53</u>		REGISTRAR'S SIGNATURE <u>Heraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Vine West, Appleton &amp; Jones, Inc., 1905/</u>			

WRITE PLAINLY—USING UNFAADING 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 Eugene English

Licensed Embalmer No. 4103

P. O. Address 440 State and

K. E. Jones

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.