

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

42990

State File No.

V. S. No. 300
REV. 10.48

FILED DEC 15 1953

5563

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> c. LENGTH OF STAY (in this place) <u>25 yrs.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Mary's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> * STREET ADDRESS (If rural, give location) <u>50 601 E. Armour 3508</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Harry</u> c. (Last) <u>Karr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 24, 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 11, 1893</u>
9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Foreman - Goetz</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brewing Co.</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		14. NAME OF HUSBAND OR WIFE <u>Zola Karr</u>	
13a. FATHER'S NAME <u>William E. Karr</u>		13b. MOTHER'S MAIDEN NAME <u>Sallie Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-07-8178</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Zola Karr, 601 E. Armour, K.C. Mo.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>Septicemia</u> <u>Nephritis - sub-acute</u> <u>Hyperostrophic arthritis</u> <u>Coronary Thrombosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>11/1/53</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>6010X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>Jan 19/45</u> to <u>11/24</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>53</u> , and that death occurred at <u>11:20 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Edson C. Carrier, M.D.</u> (Degree or title)		23b. ADDRESS <u>242 Plaza Med Bldg.</u>	
23c. DATE SIGNED <u>11/24/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>11/27/53</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Glenwild</u>		24d. LOCATION (City, town, or county) (State) <u>Cleveland, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11-25-53</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCLURE UND. CO.</u>		ADDRESS <u>K.C. MO.</u>	

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

Dr. E. C. Carrier
Plaza Medical Bldg.
Va. 3434

TOD 11:20 AM

Int 3:00 to 5:00

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.....

Licensed Embalmer No. 4904

P. O. Address H. E. Ma

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.