

43210

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5690

FILED DEC 23 1953

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. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 34 yrs.		d. STREET ADDRESS (If rural, give location) 107 North Indiana Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		9. AGE (In years last birthday) 67	
3. NAME OF DECEASED (Type or Print) a. (First) Adam b. (Middle) G. c. (Last) TEASON		4. DATE OF DEATH (Month) (Day) (Year) Dec. 1, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-24-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator		10b. KIND OF BUSINESS OR INDUSTRY KC Star	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
13a. FATHER'S NAME John Teason		13b. MOTHER'S MAIDEN NAME Victoria Perra	14. NAME OF HUSBAND OR WIFE Lillian Teason
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 486-05-4268	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lillian Teason, 107 N. Indiana, KC, 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) Cor Pulmonale, acute and chronic ANTECEDENT CAUSES DUE TO (b) Pulmonary emphysema. DUE TO (c) unknown II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 10 days	
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 <u>10-19</u> , 19 <u>53</u> to <u>12-1</u> , 19 <u>53</u> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <u>12-1</u> , 19 <u>53</u> , and that death occurred at <u>9:10 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE W. W. Dodson		23b. ADDRESS 1010 Professional Building	23c. DATE SIGNED 12-2-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-4-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington
24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar, Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 12-3-53		REGISTRAR'S SIGNATURE Sheldine Smith	

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

6811154

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 Melvin Portner

Licensed Embalmer No. 4903

P. O. Address K.C. Mo

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.