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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1312**

FILED JAN 27 1954

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **39**

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

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) OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 3 1/2 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	d. STREET ADDRESS (If rural, give location) 3108 0 10 512 Woodland
d. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Nursing Home			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) John	b. (Middle) Wesley	c. (Last) Foreman	(Month) Jan	(Day) 2	(Year) 1954

5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 6 - 1873	9. AGE (In years, last birthday) 80	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright	10b. KIND OF BUSINESS OR INDUSTRY Southern Milling Co.	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lillie Belle Foreman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 500-03-8429A	17. INFORMANT'S SIGNATURE OR NAME Mrs. H. B. Melligan	ADDRESS K.C., Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Broncho	DUE TO (b) Cerebro-vascular		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) thrombosis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			332X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **1951**, to **Jan 2, 1954**, that I last saw the deceased alive on **Dec 27, 1953** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE M. L. Friedman (Degree or title) M.D.	23b. ADDRESS 414 Arapahoe Bldg	23c. DATE SIGNED 1-4-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 6 - 1954	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 1-5-54	REGISTRAR'S SIGNATURE Heraldine Smith	FUNERAL DIRECTOR'S SIGNATURE C. N. Blackman & Son Inc.	ADDRESS K.C., Mo
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134-2029

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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address Kansas City

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.