

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5056**  
Registrar's No. **721**

FILED MAR 15 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	c. LENGTH OF STAY (in this place) <b>4 days</b>	c. CITY OR TOWN <b>MISSOURI CITY</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OSTEOPATHIC HOSP.</b>		e. STREET ADDRESS (If rural, give location) <b>6000</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>OLIA</b>	b. (Middle) <b>(NONE)</b>	c. (Last) <b>SELLS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>FEB. 15 1954</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG. 4, 1896</b>	9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months <b>57</b> Days	IF UNDER 24 HRS. Hours <b>57</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>SEDALIA, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>JAMES BAUGH</b>	13b. MOTHER'S MAIDEN NAME <b>KATHERINE MOON</b>	14. NAME OF HUSBAND OR WIFE <b>RICHARD SELLS</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Richard Sells</b>	ADDRESS <b>MISSOURI CITY MO.</b>
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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 <b>4 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebro-Vascular Hemorrhage</b>		unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b> <b>Arteriosclerotic-hypertensive</b> DUE TO (c) <b>Cardiovascular disease</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>443X</b>

19a. DATE OF OPERATION <b>NONE</b>	19b. MAJOR FINDINGS OF OPERATION <b>Spinal tap - bloody</b>	20. AUTO. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>NONE</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-None-</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>NONE</b>	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 **2-12, 1954**, to **2-15, 1954**, that I last saw the deceased alive on **2-15, 1954**, and that death occurred at **9:04 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. N. Gillum</b> (Degree or title) <b>D.O.</b>	23b. ADDRESS <b>926-517th K.C. MO</b>	23c. DATE SIGNED <b>2-15-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>2-17-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT. WASHINGTON CEN</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO</b>
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DATE REC'D BY LOCAL REG. <b>2-15-54</b>	REGISTRAR'S SIGNATURE <b>Seraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. ...</b>	ADDRESS <b>...</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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. 43

P. O. Address Liberty

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.