

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27126**
3187

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) OR TOWN KANSAS CITY		c. LENGTH OF STAY (in this place) 20 yrs		c. CITY OR TOWN Kansas City		Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION 2425 COLLEGE				e. STREET ADDRESS (If rural, give location) 311 2425 College 3378				0		
3. NAME OF DECEASED (Type or Print) a. (First) BARBARA			b. (Middle) ANNE			c. (Last) CARTER		4. DATE OF DEATH (Month) (Day) (Year) 6 22 54		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11-20-18 72		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRK. Hours	IF UNDER 1 HRK. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (City and State or Foreign Country) Emporia Kans			12. CITIZEN OF WHAT COUNTRY? U. S.		
13a. FATHER'S NAME John Carter			13b. MOTHER'S MAIDEN NAME Elysebeth Leagle			14. NAME OF HUSBAND OR WIFE No.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Howard C Brown, New Rochelle N.Y.						
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4200		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE Natural		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 _____, 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 Hugh H. Owens (Degree or title)				23b. ADDRESS 70 34 State Bldg				23c. DATE SIGNED 6-22-54		
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE 7/9/54		24c. NAME OF CEMETERY OR CREMATORY Mt. Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Kans				
DATE REC'D BY LOCAL REG. 7-9-54		REGISTRAR'S SIGNATURE Geraldine Smith			FUNERAL DIRECTOR'S SIGNATURE ADDRESS John P. Shiel 902 W. 12th					

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed.....
John P. Shiel

Licensed Embalmer No. 362

P. O. Address K C 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.