

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27889

State File No.

FILED AUG 20 1954

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>3026</u>		Registrar's No. <u>324</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Independence</u>)		c. LENGTH OF STAY (in this place township) <u>Since 1936</u>		c. CITY OR TOWN <u>Independence</u>		d. 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 <u>1333 South Nocker</u>				e. STREET ADDRESS (If rural, give location) <u>1333 South Nocker</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Parker</u> c. (Last) <u>Storm</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug-14-54</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>April-22-1872</u>	
9. AGE (In years last birthday) <u>82</u>		10. UNDER 1 YEAR Months <u>13</u> Days <u>22</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Galesburg - Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13a. FATHER'S NAME <u>Peter L. Storm</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Walk</u>			14. NAME OF HUSBAND OR WIFE <u>Laura B. Storm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Laura B. Storm Indep. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Generalized arteriosclerosis</u> <u>Obliterative arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>of right lower extremity</u> <u>amputation of upper</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>4</u> <u>11</u> <u>4200</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>right thigh (8/3/1950)</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) m.		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>Dec 25, 1929</u> , to <u>8/14, 1954</u> , that I last saw the deceased alive on <u>8/13, 1954</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Chas. Grason M.D.</u>				23b. ADDRESS <u>Independence Mo.</u>		23c. DATE SIGNED <u>8/14/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug-16-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>		24d. LOCATION (City, town, or county) (State) <u>Independence Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-16-54</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roland R. Speaks</u>		ADDRESS <u>Indep Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Raymond M. Hardy*.....

Licensed Embalmer No. *491*.....

P. O. Address *Floyd, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.