

FILED SEP 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30608
Registrar's No. 4170

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence) before a. STATE Mo 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) 2 1/2 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6801 Independence Ave		STREET ADDRESS (If rural, give location) 6801 Independence Ave	

3. NAME OF DECEASED (Type or Print) MARY			4. DATE OF DEATH (Month) (Day) (Year) 8 29 54		
a. (First)	b. (Middle)	c. (Last) HALCOAN	5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH 2 1893	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE Ark	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Ukn		13b. MOTHER'S MAIDEN NAME Ukn		14. NAME OF HUSBAND OR WIFE Curtis Holcom	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 49		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Professor Smith K C 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tubar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. Pulmonary Tuberculosis		490X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) 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)		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 1039 North Blvd			23c. DATE SIGNED 8-30-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/31/54		24c. NAME OF CEMETERY OR CREMATORY Mt Washington		24d. LOCATION (City, town, or county) (State) Kansas City Mo		
DATE REC'D BY LOCAL REG. 8-31-54		REGISTRAR'S SIGNATURE Geraldine Smith			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Skeel Funeral Home K C Mo			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 *Thomas A. Steel*.....

Licensed Embalmer No. *495*

P. O. Address *F. C. M.*

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.