

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

30819

4371

|  |                                  |   |  |  |  |   |                                  |
|--|----------------------------------|---|--|--|--|---|----------------------------------|
| BIRTH NO. _____  |                                  | REG. DIST. NO. <u>149</u>   |  | PRIMARY REG. DIST. NO. <u>1002</u>   |  | Registrar's No. _____   |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>Jackson</u> |  |   |                                  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br><u>Town Kansas City</u>  |                                  | c. LENGTH OF STAY (in this place)<br><u>65 yrs</u>  |  | c. CITY OR TOWN<br><u>5 TOWN Kansas City</u>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                                  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>General Hospital #1</u>  |                                  |   |  | f. STREET ADDRESS (If rural, give location)<br><u>5620 Bonita</u> <u>23</u>  |  |   |                                  |
| 3. NAME OF DECEASED<br>(Type or Print)   |                                  | a. (First)<br><u>Mary</u>   |  | b. (Middle)<br><u>Ellen</u>  |  | c. (Last)<br><u>Seevers</u>   |                                  |
| 4. DATE OF DEATH   |                                  | (Month)   |  | (Day)  |  | (Year)  |                                  |
|  |                                  | <u>9</u>  |  | <u>10</u>  |  | <u>54</u>   |                                  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Widowed</u>  |  | 8. DATE OF BIRTH<br><u>6-29-71</u>   | 9. AGE (in years last birthday)<br><u>83</u> | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Jacksonville, Ill.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                  |
| 13a. FATHER'S NAME<br><u>Samuel Lawson</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Martha Landers</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Mark Seevers</u>   |  |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Stella Painter</u>   |  |   |                                  |
| (If yes, give war or dates of service)   |                                  |   |  | ADDRESS<br><u>5628 E. 12 K.C.M.</u>  |  |   |                                  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, 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) <u>Acute bilateral pyelonephritis</u>  |  |  |  |   |                                  |
|  |                                  | ANTECEDENT CAUSES<br>DUE TO (b) <u>with abscess formation</u>   |  |  |  |   |                                  |
|  |                                  | DUE TO (c)  |  |  |  |   |                                  |
|  |                                  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |   | <u>6:00</u>                      |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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>6-11-54</u> , 19 <u>54</u> , to <u>9-10-</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-10-</u> , 19 <u>54</u> , and that death occurred at <u>5:20 p. m.</u> , from the causes and on the date stated above. |                                  |   |  |  |  |   |                                  |
| 23a. SIGNATURE<br><u>B. I. Burns</u>   |                                  |   |  | B.I. Burns (Degree or title)   |  | 23c. DATE SIGNED<br><u>9-11-54</u>  |                                  |
| 23b. ADDRESS<br><u>24 &amp; Cherry</u>   |                                  |   |  |  |  |   |                                  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 24b. DATE<br><u>9-13-1954</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Green Lawn</u>  |  | 24d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Mo</u>   |                                  |
| DATE REC'D BY LOCAL REG.<br><u>9-13-54</u>   |                                  | REGISTRAR'S SIGNATURE<br><u>neva minshall</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>C. N. Blackman</u>  |  |   |                                  |
|  |                                  |   |  | ADDRESS<br><u>son K.C.M.</u>   |  |   |                                  |

(Licensed Embalmer's Statement on Reverse Side)

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..... *Bert B. Bennett*

Licensed Embalmer No. *465*

P. O. Address *K. C. 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.