

FILED OCT 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

34118

4658

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

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 township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>34 YEARS</u>	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 <u>DOA St. MARYS HOSPITAL</u>		f. STREET ADDRESS (If rural, give location) <u>1609 EAST 89th TERRACE</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>FLORENCE</u>	b. (Middle) <u>HOY</u>	c. (Last) <u>ROUND</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 3, 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>FEB. 16, 1891</u>	9. AGE (In years last birthday) <u>63</u>	if UNDER 1 YEAR Months _____ Days _____	if UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TEACHER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>BROWN COUNTY, KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES ROUND</u>	13b. MOTHER'S MAIDEN NAME <u>MARY ANDERSON</u>	14. NAME OF HUSBAND OR WIFE _____
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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 <u>MRS. CARL M. MILLER, 1609 E 89th TERR. K.C.M.O.</u>	ADDRESS _____
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Disease</u>		<u>6 days</u>
	ANTECEDENT CAUSES Morbidity 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.			<u>4201</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from Oct 3, 1954, to Oct 3, 1954, that I last saw the deceased alive on Oct 3, 1954, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Orval T. Needels M.D.</u> (Degree or title) of	23b. ADDRESS <u>7400 WORNALL K.C., Mo</u>	23c. DATE SIGNED <u>Oct 9, 1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>OCTOBER 6, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>10-6-54</u>	REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. J. Neumann</u> ADDRESS <u>1521 BIRCH CREEK KANSAS CITY, MISSOURI</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Orval T. Needels

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 *Rollie Kessel*.....

Licensed Embalmer No. *469*

P. O. Address *K. 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.