

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41263
State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 002 Registrar's No. 5542

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) Kansas City	c. LENGTH OF STAY (in this place) 45 yrs	c. CITY OR TOWN Kansas City	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 General Hospital No. 1		f. STREET ADDRESS (If rural, give location) 2833 Mercier	

3. NAME OF DECEASED (Type or Print) a. (First) Austin	b. (Middle) G.	c. (Last) Todd	4. DATE OF DEATH (Month) (Day) (Year) 12 1 1954
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5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-7-1880	9. AGE (in years last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Brick Layer	10b. KIND OF BUSINESS OR INDUSTRY Bricklaying	11. BIRTHPLACE (City and State or Foreign Country) Jefferson City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Owen Todd	13b. MOTHER'S MAIDEN NAME No Record	14. NAME OF HUSBAND OR WIFE Mrs. Olivia L. Todd
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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. 496-09-9344	17. INFORMANT'S SIGNATURE OR NAME Mrs. Olivia L. Todd	ADDRESS 2833 Mercier
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 157x
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of pancreas		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

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)	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 Nov. 29, 1954, to Dec. 1, 1954, that I last saw the deceased alive on Dec. 1, 1954, and that death occurred at 7:37A m., from the causes and on the date stated above.

23a. SIGNATURE <i>B. I. Burns</i>	B. I. Burns (Degree or title) M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 12-1-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-3-54	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 12-2-54	REGISTRAR'S SIGNATURE <i>Neve Minshall</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wagner Funeral Home</i>	ADDRESS Home X 6 Mo
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

Handwritten marks

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 *Alvin R. Haunsch*.....

Licensed Embalmer No. *413*

P. O. Address *K. e. W.*.....

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.