

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11113

FILED MAY 9 1955

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 449

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Buchanan</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) <u>St. Joseph</u>		c. LENGTH OF STAY (If this place) <u>3 Yrs</u>	c. CITY OR TOWN <u>Kansas City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>		f. STREET ADDRESS (If rural, give location) <u>4127 Locust St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Edna</u>	b. (Middle) <u>L.</u>	c. (Last) <u>White</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 27, 1955</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>Married</u>	8. DATE OF BIRTH <u>April 4, 1899</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Michael Jennings</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lee White</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Lee White</u>	ADDRESS <u>4127 Locust St. K.C. Mo.</u>
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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 <u>3 Yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>		
	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. <u>Psychotic</u>		3 Yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>002 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 Apr. 26, 1955, to Apr. 27, 1955, that I last saw the deceased alive on Apr. 26, 1955, and that death occurred at 1:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>O.E. Cousins M.D.</u>	23b. ADDRESS <u>State Hospital # 2</u>	23c. DATE SIGNED <u>Apr. 27, 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Apr. 30, 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>May 2, 1955</u>	REGISTRAR'S SIGNATURE <u>Esther M. Allison</u>	485-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman W. Sidenfaden</u>	ADDRESS <u>St. Joseph, Mo.</u>
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APR 9 1957

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 *Robert H. Gaper*.....
Licensed Embalmer No. 3308

P. O. Address St. Joseph.

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.