

FILED MAY 16 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12058

State File No. ....

1803

|   |                                  |   |   |   |   |  |  |
|---|----------------------------------|---|---|---|---|--|--|
| BIRTH NO. _____   |                                  | REG. DIST. NO. <u>149</u>   |   | PRIMARY REG. DIST. NO. <u>1002</u>  |   | Registrar's No. <u>1803</u>  |  |
| 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> b. COUNTY <u>Jackson</u> |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give townshp)<br><u>Kansas City</u>   |                                  | c. LENGTH OF STAY (in this place)<br><u>42 Years</u>  |   | c. CITY OR TOWN <u>Kansas City</u>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>204 Westport Road</u>   |                                  |   |   | STREET ADDRESS (If rural, give location)<br><u>204 Westport Road</u>  |   |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Mabel</u><br>b. (Middle) <u>Jeanette</u><br>c. (Last) <u>Miller</u>  |                                  |   | 4. DATE OF DEATH<br>(Month) <u>April</u> (Day) <u>23</u> (Year) <u>1955</u> |   |   |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Divorced</u>   | 8. DATE OF BIRTH<br><u>July 23, 1893</u>                                    | 9. AGE (In years last birthday)<br><u>61</u>  | IF UNDER 1 YEAR<br>Months _____ Days _____                                  | IF UNDER 14 HRS.<br>Hours _____ Min. _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Proprietor</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Beauty Shop</u>   |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Beardstown, Pa.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>Harry B. Cates</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Clara Malotte</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>--</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>500-28-5573</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS<br><u>K.C. KADDESS</u><br><u>Mrs. R. M. Miller, 1058 Quindaro Blvd.</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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><br><br><br><br><br><br><br><br><br><br><u>4201</u>  |  |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><u>Natural</u>  |                                  | 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 _____, 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 <u>Hugh H. Owens</u> (Degree or title) <u>3</u>  |                                  |   |   | 23b. ADDRESS<br><u>1034 Quindaro Blvd</u>   |   | 23c. DATE SIGNED<br><u>4-23-55</u>   |  |
| 24a. BURIAL CREMATION REMOVAL (Specify)<br><u>Burial</u>  |                                  | 24b. DATE<br><u>April 25, 1955</u>  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park,</u>                 |   | 24d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Kansas</u> |  |  |
| DATE REC'D BY LOCAL REG.<br><u>4-23-55</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Neva Minshall</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS<br><u>Freeman Mortuary Kansas City, Mo.</u>  |   |  |  |

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

5-136

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 *Clayton R. Barnes*

Licensed Embalmer No. 479

P. O. Address *R. C., Md.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.