

FILED AUG 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22086**
Registrar's No. **3219**

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
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) OR TOWN Kansas City,		c. LENGTH OF STAY (in this place) 75 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 6833 Oak Terr.				STREET ADDRESS (If rural, give location) 6833 Oak Terr. 3968				
3. NAME OF DECEASED (Type or Print) ADELAIDE			a. (First) _____		b. (Middle) V.		c. (Last) DEW.	
4. DATE OF DEATH July 29, 1955		(Month) (Day) (Year)		5. SEX female		6. COLOR OR RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Oct. 3, 1866		9. AGE (to years last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Louisville, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Peter Sharon			13b. MOTHER'S MAIDEN NAME Bridget McCall			14. NAME OF HUSBAND OR WIFE Charles F. Dew		
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. —0—		17. INFORMANT'S SIGNATURE OR NAME Mrs. J. R. Wasson—6833 Oak Terr. ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		DUPLICATE				9 years		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				DUPLICATE		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Generalized Arteriosclerosis				42 years		
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS				_____		
Conditions contributing to the death but not related to the disease or condition causing death.		_____				_____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT (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 <u>2-21</u> , 19 <u>46</u> , to <u>7-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>53</u> , and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.								
23a. SIGNATURE Hubert M. Parker MD (Degree or title) ^D				23b. ADDRESS 520 Ogyle		23c. DATE SIGNED 7-29-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE August 1, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
DATE REC'D BY LOCAL REG. 7-29-55		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE Quirk & Tobin—20 W. Linwood, K.C. Mo. ADDRESS _____				

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

Hubert M. Parker

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 *James E. Backler*.....

Licensed Embalmer No. *45*.....

P. O. Address *K. E. S.*.....

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.