

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33262**
4506
Registrar's No.

FILED NOV 10 1955

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN mission	
c. LENGTH OF STAY (in this place) 9 days		d. STREET ADDRESS (If rural, give location) 5120 Riggs	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Hedge	b. (Middle) _____	c. (Last) Hart	4. DATE OF DEATH (Month) (Day) (Year) 10-19-55
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, (WIDOWED) DIVORCED (Specify) 2	8. DATE OF BIRTH April 16-1877	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 4 Days 3	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) Animal Industry	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Vermont Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Albert-E-Hart	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Vivian Hart
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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. No	17. INFORMANT'S SIGNATURE OR NAME Mrs Sarah A. Lewis ADDRESS Mission Kansas
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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 2 days about 1 year 7 mo. 332X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerosis DUE TO (c) Diabetes Mellitus	
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"/>
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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)	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 **Jan 12, 1954** to **Oct 12, 1955**, that I last saw the deceased alive on **Oct 11, 1955** and that death occurred at **5:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE E. J. Parks (Degree or title) 2	23b. ADDRESS Mission Kansas	23c. DATE SIGNED 10/20/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE 10-19-55	24c. NAME OF CEMETERY OR CREMATORIUM Shawnee	24d. LOCATION (City, town, or county) (State) Shawnee Kansas
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DATE REC'D BY LOCAL REG. 10-21-55	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Paul C. ... ADDRESS Shawnee, Kans.
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(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed.....

Erwin E. Russell

Licensed Embalmer No. *4811*

P. O. Address, *Shawnee, Kan.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.