

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33417

State File No. ....

FILED NOV 10 1955

4576

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>DEKALB</u>					
b. CITY OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>6 days</u>		c. CITY OR TOWN <u>CLARKSDALE</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>03201</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALVA</u>			b. (Middle) <u>L</u>		c. (Last) <u>MINGUS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 21-55</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>5/12/1891</u>		9. AGE (in years last birthday) <u>64</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Millwright Supt</u>				10b. KIND OF BUSINESS OR INDUSTRY: _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>CARLOS MINGUS</u>			13b. MOTHER'S MAIDEN NAME <u>FLORENCE RUTHERFORD</u>			14. NAME OF HUSBAND OR WIFE <u>NOBA MINGUS</u>			
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>49509-7990</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>MRS. T. E. PRATER 6021 OAK RD. MO.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma, Right Ureter</u>						INTERVAL BETWEEN ONSET AND DEATH <u>180+</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES							
		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
19a. DATE OF OPERATION <u>Aug. 1955</u>		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Probable Cerebral Metastases</u>							
19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Ureter</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
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) (Min.) _____		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>July</u> , 19 <u>55</u> , to <u>10/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>55</u> , and that death occurred at <u>7:55 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Thomas E. McMillan</u> (Degree or title) <u>MD</u>					23b. ADDRESS <u>1819 Professional Bldg. Kansas City 2700</u>		23c. DATE SIGNED <u>10/21/55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-21-55</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Marionville, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>10-21-55</u>		REGISTRAR'S SIGNATURE <u>Irene Marshall</u>			25 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>D. W. Newcomer 711 E. Mo</u>				

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

1931. 23. 11991

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 *John Kalsbeek*.....  
Licensed Embalmer No. *494*  
P. O. Address: *No. K. E. M.*

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.