

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36930

State File No. \_\_\_\_\_

4809

FILED NOV 23 1955

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1602</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>36 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		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 <b>5539 Elmwood</b>				e. STREET ADDRESS (If rural, give location) <b>76 5539 Elmwood</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>M</b> c. (Last) <b>MAPLES</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 7 1955</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept 28 1882</b>		
9. AGE (in years last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days		IF UNDER 1 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <b>Topeka Kansas</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13a. FATHER'S NAME <b>William Williams</b>		13b. MOTHER'S MAIDEN NAME. <b>Whitten</b>		14. NAME OF HUSBAND OR WIFE <b>John Maples</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Maples 5539 Elmwood</b>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart disease</b>  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.					INTERVAL BETWEEN ONSET AND DEATH  <b>4200</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Natural</b>		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 <b>Hugh H. Owens</b> (Degree or title) <sup>3</sup>			23b. ADDRESS <b>1034 Pratt Bldg</b>			23c. DATE SIGNED <b>11-8-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov 9, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>		
DATE REC'D BY LOCAL REG. <b>11-8-55</b>		REGISTRAR'S SIGNATURE <b>neva minshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sheil Funeral Home Kansas City Mo.</b>				

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

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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 *Thomas A. Shea*.....

Licensed Embalmer No. *49*.....

P. O. Address *K. O. W.*.....

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.