

40471

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 28 1955

5155

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>5155</u>			
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) Kansas City		c. LENGTH OF STAY (If this place) <u>3 days</u>		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Northeast Hospital				e. STREET ADDRESS (If rural, give location) 645 Lewis					
3. NAME OF DECEASED (Type or Print)		a. (First) Emma		b. (Middle) Anna		c. (Last) CLEMENT			
4. DATE OF DEATH		(Month) Nov		(Day) 27		(Year) 1955			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 22, 1888		9. AGE (In years last birthday) 67			
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____		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) Dare Co. Kentucky				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13a. FATHER'S NAME John R Womack			13b. MOTHER'S MAIDEN NAME Anna Shaw			14. NAME OF HUSBAND OR WIFE George A. Shaw Clement			
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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George A. Shaw 645 Lewis					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral & Respiratory failure ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial infarction DUE TO (c) Diabetes II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 26 hr	
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)		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>11/1</u> , 19 <u>50</u> to <u>11/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>55</u> and that death occurred at <u>6 PM</u> from the causes and on the date stated above.									
23a. SIGNATURE A. L. Gentry (Degree or title) D.O.				23b. ADDRESS 4949 Swape Parkway		23c. DATE SIGNED 11/28/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov 30, 1955		24c. NAME OF CEMETERY OR CREMATORY Mt Washington Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City Missouri			
DATE REC'D BY LOCAL REG. 11-28-55		REGISTRAR'S SIGNATURE Reva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sheil Funeral Home Kansas City Mo.					

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Thomas A. Lee*.....

Licensed Embalmer No. *44*

P. O. Address *X. C. M.*

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