

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40878

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

FILED JAN 11 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5558

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>14 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>915 Ewing</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Lukes Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>DOLLY</u>	b. (Middle) <u>GRACE</u>	c. (Last) <u>SHUMATE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 21 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 17, 1917</u>	9. AGE (In years last birthday) <u>38</u>	IF UNDER 1 YEAR Months _____ Days _____	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Lougap Ark</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Floyd C Waters</u>	13b. MOTHER'S MAIDEN NAME <u>Susie Wishon</u>	14. NAME OF HUSBAND OR WIFE <u>John M Shumate</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John M Shumate</u>	ADDRESS <u>915 Ewing</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Metastasis, Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH  <u>170X</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <u>Carcinoma breast</u> rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____		
	11. 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 <u>Radical Mastectomy of April 1955</u>	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) _____
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 April, 1955, to 12/21, 1955, that I last saw the deceased alive on 12/21, 1955, and that death occurred at 3 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Terry E. Temple M.D.</u>	23b. ADDRESS <u>807 Temple Bldg</u>	23c. DATE SIGNED <u>12/21/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec 23, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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DATE REC'D BY LOCAL REG. <u>12-21-55</u>	REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Sheil Funeral Home</u>	ADDRESS <u>Kansas City Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10.48

MAR 16 1950

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. Sheil*

Licensed Embalmer No. 49

P. O. Address *K.C.*

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.