

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5108**
308

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
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 town or township) Kansas City		c. LENGTH OF STAY (in this place) 7 Months		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital				STREET ADDRESS (If rural, give location) 3924 Tracy			
3. NAME OF DECEASED a. (First) LORETTA		b. (Middle) JANE		c. (Last) SHEARK		4. DATE OF DEATH (Month) (Day) (Year) January 21st, 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Jan. 27, 1883	
9. AGE (In years last birthday) 69		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) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Carl W. Sheark			
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 Harry E. Sheark Kansas City, Mo.			
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) pulmonary edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cardiac dilation DUE TO (c) Carcinomatous liver + peritoneum II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. coronary arteries, closed				INTERVAL BETWEEN ONSET AND DEATH 175x	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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 Pathologist 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 Jack H. Hill		(Degree or title) M.D.		23b. ADDRESS 3001 Wyandotte, H.C. Mo.		23c. DATE SIGNED 22 Jan 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-23-56		24c. NAME OF CEMETERY OR CREMATORY Newton		24d. LOCATION (City, town, or county) (State) Newton, Iowa	
DATE REC'D BY LOCAL REG. 1-22-56		REGISTRAR'S SIGNATURE Neva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary K. C. Mo.			

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

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 *J. R. Freeman*

Licensed Embalmer No. *29*

P. O. Address *F. 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.