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FILED MAR 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9075
State File No. 1039

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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 township) OR TOWN Kansas City,		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1900 Lin. Blvd Linhwood Nursing Home		STREET ADDRESS (If rural, give location) 64 3909 Highland 3648	
3. NAME OF DECEASED (Type or Print) a. (First) Mary Josephine b. (Middle) Duffey c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) March 8 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Mar. 1 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 93 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) Calloway Co. Missouri		12. CITIZEN OF WHAT COUNTRY? Usa	
13a. FATHER'S NAME Holster		13b. MOTHER'S MAIDEN NAME Mary J. Hickerson	14. NAME OF HUSBAND OR WIFE Frank Duffey
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. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Gertrude Hendrix Kas. 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4/20
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arteriosclerotic Heart Disease</i>		
	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.			

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)	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 2/20, 1956, to 3/8, 1956, that I last saw the deceased alive on 3/7, 1956, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE Leo F. Cooper (Degree or title) M.D.	23b. ADDRESS 1220 E. 31st K.C. Mo	23c. DATE SIGNED 3/8/56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 10 1956	24c. NAME OF CEMETERY OR CREMATORY Mt Moriah
24d. LOCATION (City, town, or county) Kansas City, Mo.		(State)

DATE REC'D BY LOCAL REG. 3-9-56	REGISTRAR'S SIGNATURE Mrs. Minshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs C .L. Forster Funeral Home Kas. C.MO.
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(Licensed Embalmer's Statement on Reverse Side)

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. Sigil Hanna

Licensed Embalmer No. 558

P. O. Address *J. C. M.*

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