

0.300
0.48

FILED JUN 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16284

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2244

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 (in this place) Lifetime	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 HOSPITAL OR INSTITUTION DeLora Rest Home, 622 Benton		STREET ADDRESS (If rural, give location) 622 Benton Blvd. 3188	

3. NAME OF DECEASED (Type or Print) ELLA	a. (First)	b. (Middle) MABELLE	c. (Last) CHARLTON	4. DATE OF DEATH May 22, 1956.
----------------------------------------------------	------------	-------------------------------	------------------------------	------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 10, 1879	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	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) Kansas City, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
---------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------------------------------	--	-----------------------------------------------

13a. FATHER'S NAME William T. Mc Donald	13b. MOTHER'S MAIDEN NAME Bettie B. Brasfield	14. NAME OF HUSBAND OR WIFE Frank Charlton	
---------------------------------------------------	---------------------------------------------------------	------------------------------------------------------	--

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 Mrs. H.T. Hutchison, 4218 Terrace, K.C., 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) Carcinoma of cervix		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	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.		1918

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 4-26, 1956, to 5-22, 1956, that I last saw the deceased alive on 5-22, 1956 and that death occurred at 9:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE Wilson H. Miller (Degree or title) M.D.	23b. ADDRESS 4620 Sundry Ave Kansas City, Mo.	23c. DATE SIGNED 5-23-56
----------------------------------------------------------------------	------------------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-24-56	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri.
------------------------------------------------------------	-----------------------------	-------------------------------------------------------------------	--------------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 5-23-56	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FREEMAN MORTUARY, Kansas City, Mo.	
--------------------------------------------	-----------------------------------------------	---------------------------------------------------------------------------------------	--

(Licensed Embalmer's Statement on Reverse Side)

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

Ave.
CH. 1-5750
2:30 - 6:00 P.M.
WED.

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 *Clayton H. Barnes*
Licensed Embalmer No. 479

P. O. Address *F. 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.