

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20854

STATE FILE NUMBER

FILED JUL 13 1956

Registration District No. 146

Primary Registration District No. 5-5-68

Registrar's No. 296

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, give TOWNSHIP only) OR TOWN Blue		c. CITY OR TOWN Blue	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 507 Brookside Dr		d. STREET ADDRESS (If outside, give location) 507 Brookside Dr	
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH June 30 1956	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20 1884	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Chicago Ill	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Fredrick Pischeke	
14. MOTHER'S MAIDEN NAME Rose Biatz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT George W Doering 507 Brookside Dr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:- IMMEDIATE CAUSE (a) Coronary occlusion & myocardial infarctus			INTERVAL BETWEEN ONSET AND DEATH 2 Mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetes mellitus 4201			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Mar 22 1956 to June 30, 1956 and last saw her ^{him} alive on June 30, 56 Death occurred at 9:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. G. D. Labal		22b. ADDRESS 1210 Oak Independence Mo 6-30-56	
22c. DATE SIGNED June 30 1956		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE July 3 1956		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery	
23d. LOCATION (City, town, or county) (State) Kansas City Kansas		24. FUNERAL DIRECTOR ADDRESS Sheil Funeral Home Kansas City Mo.	
25. DATE RECD. BY LOCAL REG. 7-2-56		26. REGISTRAR'S SIGNATURE [Signature]	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *Thomas A. Smith*.....

Licensed Embalmer No. *7*

P. O. Address *H. O.*

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.