

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27102

State File No.

FILED AUG 29 1956

3342

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) Kansas City		c. LENGTH OF STAY (in this place) 3 yrs.		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 General #2				e. STREET ADDRESS (If rural, give location) 917 Woodland			
3. NAME OF DECEASED (Type or Print) a. (First) Oscar		b. (Middle)		c. (Last) Rall		4. DATE OF DEATH (Month) (Day) (Year) July 29, 1956	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated		8. DATE OF BIRTH August 16, 1912	
9. AGE (In years last birthday) 43 1/2 yrs.		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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and State or Foreign Country) Morrilton, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry Rall		13b. MOTHER'S MAIDEN NAME Elsie Watson		14. NAME OF HUSBAND OR WIFE Unknown			
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. 431-11-4949		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marion Hughes, sister 917 Woodland			
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) Lobar pneumonia 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. Cerebral vascular accident due to Hypertensive Heart Disease.				INTERVAL BETWEEN ONSET AND DEATH 490X	
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) (m.)		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 <u>7-20-56</u> , 19 <u>56</u> , to <u>7-29-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-29-56</u> , 19 <u>56</u> , and that death occurred at <u>7:00 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. R. Peterson M.D.				23b. ADDRESS 600 East 22nd Street		23c. DATE SIGNED 7-31-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 3, 1956		24c. NAME OF CEMETERY OR CREMATORY Cosmopolitan Fn. Hm.		24d. LOCATION (City, town, or county) (State) Morrilton, Arkansas	
DATE REC'D BY LOCAL REG. 8-1-56		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watkins Bros. Fn. Hm. 18th & Benton			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
W. R. Peterson

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..... *Bruce R. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18th & B*

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.