

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

30854

3924

Registration District No. 149 Primary Registration District 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 COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital		Length of stay in 1b 5 days	d. STREET ADDRESS 1525 Sterling		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn O. Marlett			4. DATE OF DEATH Month Day Year Sept. 5, 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1925	9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Xray Technician		10b. KIND OF BUSINESS OR INDUSTRY Hospitals	11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Albert R. O'Roark			14. MOTHER'S MAIDEN NAME Augusta Dreis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. 491 20 2669	17. INFORMANT Address Mrs. Augusta O'Roark, Independence, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Poliomyelitis - Subto-spinal					INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____
DUE TO (c) _____					0800
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 8-31-56 to 9-5-56 and last saw her alive on 9-5-56 Death occurred at 6 A Mueller m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Martin J. Mueller (Degree or title)			22b. ADDRESS 535 Angles Bldg KCMo		22c. DATE SIGNED 9-6-56
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/7/56	23c. NAME OF CEMETERY OR CREMATORY Md. Grove Cemetery	23d. LOCATION (City, town, or county) Independence, Mo.		(State)
24. FUNERAL DIRECTOR H. C. Carson ADDRESS Independence, Mo.		25. DATE RECD. BY LOCAL REG. 9-6-56	26. REGISTRAR'S SIGNATURE Vera Marshall		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

JAN 17 1957

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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 embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Harold E. Woodruff*

Licensed Embalmer No. *46*

P. O. Address *Indep.*

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.