

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31000

STATE FILE NUMBER

3910

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>			Length of stay in 1b <u>59 yrs</u>		d. STREET ADDRESS <u>5040 E. 10th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>CELIA</u> First <u>FRANCES</u> Middle <u>WEDDIE</u> Last				4. DATE OF DEATH <u>Sept-3-1956</u> Month <u>Sept</u> Day <u>3</u> Year <u>1956</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30-1885</u>		9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Laura, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Horace H. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Eva. B. Banks</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Charles C. Weddle H. P. No.</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Coronary Artery occlusion</u>					<u>10 days</u>						
		DUE TO (c) <u>Coronary Artery Sclerosis 4201</u>					<u>5 years</u>						
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I-(a) <u>Acute Pulmonary Artery expansion - Congestive Failure</u>							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.) <u>---</u>										
20c. TIME OF INJURY Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a. m. <u>p. m.</u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>		CITY <u>---</u> COUNTY <u>---</u> STATE <u>---</u>	
21. I attended the deceased from <u>6-8-56</u> to <u>9-3-56</u> and last saw her ^{her} alive on <u>9-2-56</u> Death occurred at <u>12:05 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Graham Asher</u> (Degree or title) <u>Graham Asher M.D. MD</u>					22b. ADDRESS <u>1220 Prof. Bldg -</u> <u>Kansas City 6-700</u>		22c. DATE SIGNED <u>9-4-56</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)							
<u>Burial</u>		<u>Sept. 6-1956</u>		<u>Mt. Washington Cem.</u>		<u>Kansas City, Mo</u>							
24. FUNERAL DIRECTOR <u>C. H. Blackman & Son Inc.</u>			ADDRESS <u>---</u>		25. DATE RECD. BY LOCAL REG. <u>9-5-56</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>						

H. P. No. Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health,
Welfare
Public
Service300
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 causally related. Coroner cannot certify to a death due to natural causes.

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.....

Bert B. Benne

Licensed Embalmer No. *46*

P. O. Address *A. C. 7*

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.