

Health, Welfare Public Service

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 28 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **31091**

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 61

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) <u>Washington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>HICKMAN MILLS 7000</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>87th &amp; Hillcrest Rd</u> Length of stay in lb <u>39 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>87th Hillcrest Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>P.</u> Last <u>Siler</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1880</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
13. FATHER'S NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		17. INFORMANT Address <u>Lawrence Chandler 87 Hillcrest Rd</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.	
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>myocardial insufficiency</u> DUE TO (b) <u>Chronic hepatitis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			
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 <u>9:45 AM</u> Month, Day, Year <u>April 24, 1953</u>		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 <u>April 24, 1953</u> to <u>Sept 17, 1956</u> and last saw <sup>him</sup> alive on <u>Sept 16, 1956</u> Death occurred at <u>9:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Carl T. Moore M.D.</u>		22b. ADDRESS <u>6425 E 37th Kansas City, 29, mo</u>	
22c. DATE SIGNED <u>9-19-56</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept 19-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McClary Cem</u>	23d. LOCATION (City; town, or county) (State) <u>Kansas City Kansas</u>
24. FUNERAL DIRECTOR <u>St. Weibert K.C. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-19-56</u>	
26. REGISTRAR'S SIGNATURE <u>Deputy Goddard</u>			

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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..... *B. E. Walker*

Licensed Embalmer No..... *40*

P. O. Address..... *K.C. 8.*

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.