

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33953

STATE FILE NUMBER

FILED OCT 24 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4404

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

MEDICAL CERTIFICATION
Marcus B. Bond M.D.

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 Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2405 Denver		Length of stay in 1b 3 yrs. d. STREET ADDRESS 2405 Denver (If outside, give location) 3348 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pheba Middle J. Last Erickson		4. DATE OF DEATH Month Oct. Day 9 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1876
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 7 Days 1 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Solsberry Indiana
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME E. Woodard Crane	
14. MOTHER'S MAIDEN NAME (Sarah E.) Bayes		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. None		17. INFORMANT Address Clifford J. Erickson, 2405 Denver	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture right femur 1954			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years 332XF
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 April 1953 to Oct. 9, 1956 and last saw ^(her) alive on Oct 7, 1956 Death occurred at 11:30 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Marcus B. Bond M.D.		22b. ADDRESS Kansas City, Mo.	
22c. DATE SIGNED Oct 9, 1956		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 10-11-56		23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery	
23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar, 1800 E Linwood	
25. DATE RECD. BY LOCAL REG. 10-9-56		26. REGISTRAR'S SIGNATURE New Marshall	

(Licensed Embalmer's Statement on Reverse Side)

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.....
Licensed Embalmer No.

P. O. Address.....

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.