

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41597

FILED JAN 14 1957

STATE FILE NUMBER  
5602

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5602

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		180 c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1007 Agnes</b>			Length of stay in Institution <b>65 years</b>		d. STREET ADDRESS <b>1007 Agnes</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Oda</b> Middle <b>Udella</b> Last <b>McClelland</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 12, 1887</b>		9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Stack</b>				14. MOTHER'S MAIDEN NAME <b>Mary N. (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>496-10-6910B</b>		17. INFORMANT <b>Mr. J. C. McClelland Kansas City, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>with metastasis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia, Malnutrition</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Not Known</b> <b>162 X</b>
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 _____ 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 <b>9/12/56</b> to <b>12/25/56</b> and last saw her <sup>him</sup> alive on <b>12/25/56</b> . Death occurred at <b>8:30 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>M. W. Hulshoffman</b> (Degree or title)				22b. ADDRESS <b>5242 St. John Kansas City, Mo.</b>		22c. DATE SIGNED <b>12/26/56</b>	
23a. BURIAL, CREMATION, REMOVE (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 27, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons</b>			ADDRESS <b>Indep. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-26-56</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, County or State must be printed. Coroner cannot certify to a death due to natural causes. 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.

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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..... *Tom J. Marklan* .....

Licensed Embalmer No. *45*

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.