

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms with no standard momentary in them to. Doctor, coroner, etc: must use only standard momentary in them to. No symptoms with no standard momentary in them to.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Hugh H. Owens

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4580

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1062 Registrar's No. 387

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"/>	c. CITY OR TOWN <b>3438 43 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>General Hospital</b>		Length of stay in lb <b>2 1/2 yrs</b>	d. STREET ADDRESS <b>2632 Troost</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b></b> Last <b>Bender</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>23,</b> Year <b>1957</b>		
5. SEX <b>Male</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>12-15-1916</b>		9. AGE (In years last birthday) <b>40</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. NAME OF BUSINESS OR INDUSTRY <b>Butler Mfg. Co.</b>		11. BIRTHPLACE (City and state or country) <b>Linton, North Dakota</b>	
13. FATHER'S NAME <b>John Bender</b>			14. MOTHER'S MAIDEN NAME <b>Christine Linderman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>498-38-8912</b>		17. INFORMANT Address <b>Lela Maye Bender, Graff, Missouri</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Haematomas.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 to 26</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Fractured Shoulder</b>					
20a. ACCIDENT <input checked="" 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.) <b>Paralyzed in car that ran into truck</b>		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. <b>1-21-57</b>			20d. PLACE OF INJURY (e. g., in or about home, factory, street, office, bldg, etc.) <b>Highway Kansas City Jackson MO</b>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY <b>23</b> STATE		
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Hugh H Owens Coroner</b>			22b. ADDRESS <b>1134 Pratts Blvd</b>		22c. DATE SIGNED <b>1-25-57</b>
23a. BURIAL, CREMATION, REMOVAL (S, C, R) <b>Removal</b>		23b. DATE <b>1-23-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope</b>		23d. LOCATION (City, town, or county) (State) <b>MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>George C. Carson, Independence, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-26-57</b>		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>	

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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 *J. H. Gibson*.....

Licensed Embalmer No. *48*

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.