

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4758

FILED FEB 27 1957

State File No. 577

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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, write RURAL and give town) <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>5-9 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>OSTEOPATHIC HOSPITAL 8228</u>				e. STREET ADDRESS (If rural, give location) <u>5534 CRESTWOOD DR.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u>		b. (Middle) <u>A</u>		c. (Last) <u>HAWARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 5 57</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>JULY 17, 1885</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAGICAL INSTRUMENT</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CONCORDIA KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROBERT E. HAWARD</u>		13b. MOTHER'S MAIDEN NAME <u>MICREIA CRAIG</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>JOHN D. HAWARD</u>		ADDRESS <u>5534 CRESTWOOD DR.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Congestive heart failure</u>		<u>2 months</u>	
				DUE TO (c) <u>Hypertensive heart disease</u>		<u>10 years</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Atherosclerosis</u>		<u>443X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>1</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Dec 12, 1956</u> , to <u>Feb 5, 1957</u> , that I last saw the deceased alive on <u>Feb 4, 1957</u> , and that death occurred at <u>8:59 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Myron D. Jones</u>				23b. ADDRESS <u>926 E 11th</u>		23c. DATE SIGNED <u>2-6-57</u>	
24a. BURIAL/CREMATION (Specify) <u>BURIAL</u>		24b. DATE <u>2-7-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY KANS.</u>	
DATE REC'D BY LOCAL REG. <u>2-6-57</u>		REGISTRAR'S SIGNATURE <u>Neval Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Newcomer</u>		ADDRESS <u>703 N 10 St</u>	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD Myron D. Jones

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.....
Robert E. Heron

Licensed Embalmer No. *4887*

P. O. Address *J. C. Mc...*

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.