

FILED MAR 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4856

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 935

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) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WHEATLEY HOSPITAL</u>		Length of stay in 1b <u>2 months</u>	d. STREET (If outside, give location) ADDRESS <u>2617 HIGHLAND AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SUSIE</u> First <u>MCNACK</u> Middle <u>-----</u> Last			4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>57</u>		
5. SEX <u>FEMALE</u> <u>3</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16th 1893</u>		9. AGE (In years last birthday) <u>64 1/2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>FORT GIBSON OKLA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>GEORGE VAN</u>			14. MOTHER'S MAIDEN NAME <u>R. K.</u> <u>RUTH VAN</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. <u>NONE</u>		17. INFORMANTS <u>K.</u> Address <u>CLEOPIA MCNACK 2617 Highland Ave.</u>	
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>Uremia</u> Conditions, if any, which gave rise to above cause (d), stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Essential Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>592X</u>
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.) <u>2</u>		
20c. TIME OF INJURY Hour <u>8:15 AM</u> Month, Day, Year <u>2-13-57</u> 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 <u>2-13-57</u> to <u>2-25-57</u> and last saw her/him alive on <u>2-25-57</u> Death occurred at <u>8:15 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dwaine R. Dixon, M.D.</u> (Name or title)			22b. ADDRESS <u>2204 1/2 East 18th, Street</u>		22c. DATE SIGNED <u>2-26-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>2-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Muskogee Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>muskogee Oklahoma</u>
24. FUNERAL DIRECTOR ADDRESS <u>Adkins Funeral Home 2000 E 12th St</u>			25. DATE RECD. BY LOCAL REG. <u>2-27-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshel</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no reason. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Vewiser L. Dixon

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.....
[Handwritten Signature]

Licensed Embalmer No.....
44

P. O. Address.....
[Handwritten Address]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.