

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4991
STATE FILE NUMBER
600

FILED FEB 27 1957

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

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Mission		8160 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center			Length of stay in lb 4 days	d. STREET ADDRESS (If outside, give location) 6008 Howe Drive			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Erminna Middle TT Last Shaffer				4. DATE OF DEATH Month February Day 6 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-80	9. AGE (In years - last birthday) 77	IF UNDER 1 YEAR Months 7 Days 14 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) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) SEDWICK Sedwick, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh Samuel Hall				14. MOTHER'S MAIDEN NAME Lucilla Anderson			
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. No		17. INFORMANT Mr. Hal Shaffer - Home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Corac Failure						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Severe Myocarditis, Coracic Decomposition							
DUE TO (c) Chronic Asthma						24H	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						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.) 2				
20c. TIME OF INJURY Hour 10.30 Month Jan Day 10 Year 1957 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 1940 to 2/6/57 and last saw her alive on 2/6/57 Death occurred at 10.30 pm on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Fred Irwig M.D.				22b. ADDRESS 1610 Profers Bldg.		22c. DATE SIGNED 2/7/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-8-1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Temple		23d. LOCATION (City, town, county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR Stine & McClure - Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 2-7-57		26. REGISTRAR'S SIGNATURE New Minshell	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Fred Irwig
MEDICAL CERTIFICATION

hh, affare, lic, vice

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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. J. Walter*

Licensed Embalmer No. *211*

P. O. Address *K. C. ...*

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.