

Health, Welfare and Public Service
 000-56
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

4996

STATE FILE NUMBER

FILED MAR 13 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 834

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen' Hosp. #1		Length of stay in 1b 47 YEARS		d. STREET ADDRESS 3538 Olive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary R. Simcock			4. DATE OF DEATH Month 2 Day 20 Year 1957				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1864	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) SOUTH ARGYLE, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD REED				14. MOTHER'S MAIDEN NAME MARION BROWN			
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. NONE		17. INFORMANT Address RAIPH R. SIMCOCK, 1302 E. 32ND TERR. MO. K.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident						INTERVAL BETWEEN ONSET AND DEATH 33 1/4	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b)							
DUE TO (c)							
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 9 Month 17 Day 1957 a. m. A 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 24th & Cherry		COUNTY STATE	
21. I attended the deceased from Feb. 17, 1957 to Feb. 20, 1957 and last saw her alive on Feb. 20, 1957 Death occurred at 9:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE B. I. Burns (Degree or title) <i>B. I. Burns, M.D.</i>				22b. ADDRESS 24th & Cherry		22c. DATE SIGNED 2-20-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB. 22, 1957		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) COUNCIL GROVE KANSAS	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS, KANSAS CITY, MO.				25. DATE RECD. BY LOCAL REG. 2-21-57		26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Chester K Brown*

Licensed Embalmer No. *49*

P. O. Address *CEP*

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.