

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5080

State File No. _____

FILED FEB 18 1957

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 487

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 township) <u>Kansas City</u>		c. CITY OR TOWN <u>Lee Summit</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 weeks</u>		STREET ADDRESS (If rural, give location) <u>15415 E 113th</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Audrey</u> b. (Middle) <u>Muriel</u> c. (Last) <u>West</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 28-1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 2, 1921</u>
9. AGE (in years last birthday) <u>35 years</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Wellington New Zealand</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Albert Waugh</u>	
13b. MOTHER'S MAIDEN NAME <u>Mae</u>		14. NAME OF HUSBAND OR WIFE <u>Leroy West</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Leroy West Lee Summit, Mo.</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cerebellar hemorrhage</u>		DUE TO (b) <u>acute myelogenous leukemia</u>		<u>1 hr. 45 min</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____		<u>5 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____		<u>2041</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)	
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 1-16, 1957, to 1-28, 1957, that I last saw the deceased alive on 1-27, 1957, and that death occurred at 125 p m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert K. Skillman, M.D.</u>	(Degree or title) <u>D</u>	23b. ADDRESS <u>4635 Wyandotte, Kansas City, Mo 1-28-57</u>	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>Jan. 31-1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Independence Missouri</u>
DATE REC'D BY LOCAL REG. <u>1-31-57</u>	REGISTRAR'S SIGNATURE <u>Neva Minahall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Roland R. Speaks</u>	
		ADDRESS <u>Indep. Mo</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Robert K. Skillman

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 *Roland B. Jenkins*.....

Licensed Embalmer No. *360*

P. O. Address *Indy, Ind.*

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.