

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5161

STATE FILE NUMBER

FILED MAR 14 1957

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 15

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, also TOWNSHIP) Inside Limits OR TOWN <u>Kansas City</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			d. STREET ADDRESS (If outside, give location) Reside on Farm <u>5602 EAST 87TH STREET</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>5602 EAST 87TH ST.</u> <u>5 YRS</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARMINITA DAILY</u>			4. DATE OF DEATH Month Day Year <u>MARCH - 9 - 1957</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN - 9 - 1867</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
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>At home</u>		11. BIRTHPLACE (City and state or country) <u>MEMPHIS Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</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.		17. INFORMANT Address <u>MRS JIM O'SHAKE St. Louis Mo.</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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>15 years</u> <u>15 years</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.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year							
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>March 16, 1957</u> and last saw her/him alive on <u>March 8, 1957</u> Death occurred at <u>8:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Carl T. Moore M.D.</u>			22b. ADDRESS <u>6425 E 37th & K.C. 29, Mo</u>		22c. DATE SIGNED <u>3-9-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>MARCH 9 1957</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>MEMPHIS MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS 1331 BRUSH CREEK KANSAS CITY, MO</u>			25. DATE RECD. BY LOCAL REG. <u>3-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert E. Dillard</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of natural causes. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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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 *Basil Honey*

Licensed Embalmer No.

P. O. Address *N.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.

Handwritten mark