

FILED MAR 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8624

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1104

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</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>INDIAN HILLS</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>ST. JOSEPH'S HOSPITAL</u>		Length of stay in lb <u>3 MONTHS</u>	d. STREET ADDRESS <u>2701 WEST 67TH TERR</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>REE</u> Middle <u>M.</u> Last <u>DALEY</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1895</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>71</u> Days <u>21</u> Hours <u>0</u> Min. <u>0</u>	
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>-----</u>		11. BIRTHPLACE (City and state or country) <u>DAVIS COUNTY, MISSOURI</u>	
13. FATHER'S NAME <u>JOHN B. MARKEY</u>			14. MOTHER'S MAIDEN NAME <u>FLORA BELLE PEERY</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. INFORMANT Address <u>MR. D. BERNARD DALEY 2701 WEST 67TH TERRACE INDIAN HILLS, KANSAS</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>Arteriosclerotic heart disease with congestive heart failure.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
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>Feb. 1, 1957</u> to <u>March 8, 1957</u> and last saw her alive on <u>Mar. 8, 1957</u> Death occurred at <u>11:40 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>Albert I. Decker MD</u>			22b. ADDRESS <u>Kansas City, Mo.</u>		22c. DATE SIGNED <u>3/9/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR-11-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CAREN KANSAS CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>3-9-57</u>	26. REGISTRAR'S SIGNATURE <u>near Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

Director, coroner, etc. must use only standard momentary ink on the certificate. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Albert I. Decker

MEDICAL CERTIFICATION

ST. Joseph Hosp.
BY EMBALMER

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 *KC*

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.