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ALL INFORMATION ON THIS CERTIFICATE IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT OR TO THE STATE DEPARTMENT OF HEALTH. CORONER CANNOT CERTIFY TO A DEATH DUE TO NATURAL CAUSES.

FILED MAR 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **8933**  
REGISTRAR'S NO. **1082**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>KANSAS CITY</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b> Length of stay in <b>33 YEARS</b>		d. STREET ADDRESS (If outside, give location) <b>6934 WALDRON AVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ARTIE</b> Middle <b>C</b> Last <b>TERRILL</b>			4. DATE OF DEATH <b>MARCH - 4 - 1957</b> Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 18, 1893</b>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>HUNTSVILLE, MISSOURI</b>		
13. FATHER'S NAME <b>WILLIAM BOHN</b>			14. MOTHER'S MAIDEN NAME <b>CHRISTINA SANDERSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>496-24-2371</b>		17. INFORMANT <b>JOHN A. TERRILL</b> Address <b>6934 WALDRON AVE. KANSAS CITY, MO.</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma - primary unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>1999</b>
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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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 <b>26 Dec 1956</b> to <b>4 March 1957</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>3 March 57</b> Death occurred at <b>2:33 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <b>Blaine Z. Hibbard M.D.</b>	22b. ADDRESS <b>411 Nichols Rd KCMo</b>	22c. DATE SIGNED <b>4 March 57</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MARCH 7, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>DW. NEWCOMER'S SONS 1331 BRUSH CREEK KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>3-7-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Blaine Z. Hibbard

MEDICAL CERTIFICATION

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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 *Chester K Brown*

Licensed Embalmer No. *48*

P. O. Address *CEM*

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.