

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH12967
STATE FILE NUMBER

FILED MAY 1 - 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1708

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, 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>Kansas City</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>Colonial Nursing Home</u>		Length of stay in lb <u>40 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>4036 Charlotte Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Wila</u> Middle <u>E.</u> Last <u>ARENS</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>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>April 1, 1878</u>	9. AGE (In years last birthday) <u>79</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Oakfield, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Porter L. Howard</u>		13b. MOTHER'S MAIDEN NAME <u>Acasta G. Roe</u>		14. NAME OF HUSBAND OR WIFE <u>Hubert ARENS</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>ALICE W. MANNING, COUNCIL GROVE, KANS.</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>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>				<u>3 yrs</u>	
DUE TO (c) <u>Arterio sclerosis</u>				<u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NO</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <u>None</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 1, 1957</u> and last saw her alive on <u>April 2, 1957</u> Death occurred at <u>8:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>M. B. Casbolt MD</u> (Degree or title) <u>D</u>			22b. ADDRESS <u>4000 Baltimore</u>		22c. DATE SIGNED <u>4/13/57</u>
23a. BURIAL CREMATION, (Specify)		23b. DATE <u>April 15, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
24. FUNERAL DIRECTOR <u>D. W. Newcomer's Sons</u>		ADDRESS <u>1331 Brook Park K.C. Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-13-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

M. B. Casbolt MD USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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1-57



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 *Everett L. Smith*

Licensed Embalmer No. *5001*

P. O. Address *H. C. 710*

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.