

FILED APR 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

1594

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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) OR TOWN <b>Kansas City</b>		Inside Limits 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>Gen'l Hosp. #1</b>			Length of stay in 1b <b>50 yrs.</b>			d. STREET ADDRESS (If outside, give location) <b>6624 E. 13</b>		
3. NAME OF DECEASED (Type or print) <b>Virginia Fields</b>				4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>1957</b>				
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>April 16, 1880</b>		9. AGE (In years last birthday) <b>76</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Adkins</b>				14. MOTHER'S MAIDEN NAME <b>Rhoda Hall</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Walter Fields 2118 No. 43 K<sup>U</sup> Kan.</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>Cerebrovascular accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4-57</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Intertrochnateric fracture of right hip</b>							<b>2903<sup>3</sup> 20</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochnateric fracture of right hip</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
20a. ACCIDENT <input checked="" 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.) <b>Fall in bathroom</b>					
20c. TIME OF INJURY Hour _____ a. m. _____ <b>2-15-57</b>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Above address</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		STATE <b>Jackson Missouri</b>		
21. I attended the deceased from <b>Feb. 16, 1957</b> to <b>April 3, 1957</b> and last saw her alive on <b>April 3, 1957</b> ✓ Death occurred at <b>9:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>B. I. Burns (Degree or title)</b>				22b. ADDRESS <b>24th &amp; Cherry</b>		22c. DATE SIGNED <b>4-3-57</b>		
23a. BURIAL, CREMATION, etc. (Specify) <b>Burial</b>		23b. DATE <b>4-6-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>			
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City, Mo.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-5-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

MEDICAL CERTIFICATION

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.....  
*Thomas A. Shiel*

Licensed Embalmer No. *495*

P. O. Address *K. C. Mass*

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.