

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13202

STATE FILE NUMBER

1494

FILED APR 16 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP or TOWN) Kansas City		- Inside Limits Yes# No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3530 Campbell			Length of stay in lb 6 yrs		d. STREET ADDRESS 3527 Campbell		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lula Middle Maude Last James				4. DATE OF DEATH Month March Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1893	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kirksville Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Alfred Reynolds				14. MOTHER'S MAIDEN NAME Emma Susan Brassfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Alice J. Walls Address K. C. Mo 3530 Campbell			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac Hypertrophy							6 years
DUE TO (c) Malignant Hypertension							1 year
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 9 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		COUNTRY STATE	
21. I attended the deceased from Feb. 15, 1944 to March 30, 1957 and last saw her alive on 3-30-57 Death occurred at 9 PM m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Emmett F. Walls (Degree or title)				22b. ADDRESS 2628 Troost		22c. DATE SIGNED 3-30-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/31/57		23c. NAME OF CEMETERY OR CREMATORY Fort Madison		23d. LOCATION (City, town, or county) (State) Kirksville Mo.	
24. FUNERAL DIRECTOR Stine & McClure ADDRESS K. C. Mo.			25. DATE RECD. BY LOCAL REG. 3-30-57		26. REGISTRAR'S SIGNATURE Mrs. Minshall		

(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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Emmett F. Walls D. O.

MEDICAL CERTIFICATION

300
1-56

APR 2 1958

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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 *Elmo D. Zipl*

Licensed Embalmer No. 481

P. O. Address *Kansas City*

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.