

FILED MAY 7 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

133888
STATE FILE NUMBER 1874

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

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Length of stay in 1b 72 yrs	d. STREET ADDRESS (If outside, give location) 5500 Lydia AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle D. Last SAMS			4. DATE OF DEATH Month April Day 16 Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1872	9. AGE (In years last birthday) 84 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	11. BIRTHPLACE (City and state or country) Jeddo Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME William Sams		13b. MOTHER'S MAIDEN NAME JANE Lockhart	14. NAME OF HUSBAND OR WIFE None		
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Kate Sams Address 5500 Lydia K.C. Mo.		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli bilateral			INTERVAL BETWEEN ONSET AND DEATH 4200
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial thrombosis			
DUE TO (c) Atherosclerotic heart disease			
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 checked="" 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.)				
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from **Feb. 5, 1957** to **Apr. 16, 1957** and last saw her alive on **Apr. 16, 1957**
Death occurred at **10:50 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Don A. Black (Degree or title) D	22b. ADDRESS M.D. 924 Professional Bldg.	22c. DATE SIGNED 4/17/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE APRIL 20 1957	23c. NAME OF CEMETERY OR CREMATORY D.W. NEWCOMER'S SONS	23d. LOCATION (City, town, or country) (State) KANSAS City MISSOURI
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons ADDRESS 1331 Brush Creek 15. C. Mo.	25. DATE RECD. BY LOCAL REG. 4-20-57	26. REGISTRAR'S SIGNATURE new minahell
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All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Don A. Black

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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 *E. Scott D. Smith*

Licensed Embalmer No. *5001*

P. O. Address *K. C. Mo.*

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.