

THE DIVISION OF HEALTH AND PUBLIC SERVICE
STANDARD CERTIFICATE OF DEATH

16521

STATE FILE NUMBER

FILED JUN 3 1957

Registration District No. 72

Primary Registration District No. 5289

Registrar's No. 47

Health, Welfare
Public
Service

300
1-56

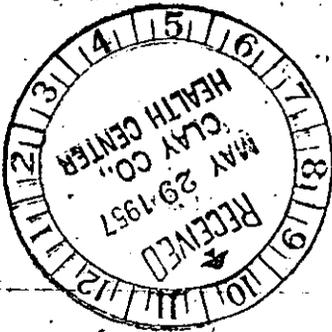
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY CLAY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CLAY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gladstone		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Gladstone		6000 0 Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1204 E 64th		Length of stay in lb 1 YR	d. STREET ADDRESS (If outside, give location) 1204 E. 64th		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lulu Middle Belle Last MORSE			4. DATE OF DEATH Month MAY Day 23 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 20 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Brock, Neb R		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Robert Knapp			14. MOTHER'S MAIDEN NAME Jessie Percival		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-34-8227	17. INFORMANT Address HARLEY L. MORSE Gladstone, Mo		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebrovascular Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH. 5-10 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ... 33ix					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 _____ to _____ and last saw her/him alive on _____ Death occurred at 11:00 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Weldon L. Sportsworn M.D. (Degree or title)			22b. ADDRESS Route #1 Goshute Mo		22c. DATE SIGNED 5-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE MAY 27, 1957	23c. NAME OF CEMETERY OR CREMATORY Bedford Cemetery		23d. LOCATION (City, town, or county) (State) Howe, Nebraska	
24. FUNERAL DIRECTOR D.W. Newcomer Sons N.K.C.		25. DATE RECD. BY LOCAL REG. 5-24-57		26. REGISTRAR'S SIGNATURE Alice L. Humphrey Deputy	

(Licensed Embalmer's Statement on Reverse Side)

Dr. Sportsman



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 *John W. Kalsbeck*

Licensed Embalmer No. *4949*

P. O. Address *No. Kansas*

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.