

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17304

FILED JUN 5 1957

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2268

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) 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 HOSPITAL OR INSTITUTION Westwood Med. Hospital		Length of stay in 1b 35 YEARS	d. STREET ADDRESS 526 WEST 39th AVE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROSE Middle HELEN Last RANK			4. DATE OF DEATH MAY 13, 1957		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1894	9. AGE (In years, Months, Days, Hours, Min.) 61 YRS 7 MO 13 D	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY Physicians App. Co		11. BIRTH PLACE (City and state or country) LENA, ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John REES		13b. MOTHER'S MARDEN NAME Sofia MURRAY	
14. NAME OF HUSBAND OR WIFE Louis RANK		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. 495-10-0160	
17. INFORMANT MR Richard A. Erickson		Address K.C. Mo. Temple Bldg.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral arterio sclerosis DUE TO (c) _____ 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 5-23-53 to 5-13-57 and last saw her alive on 5-13-57 Death occurred at 6:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Daniel F. Hogan		(Degree or title) MD		22b. ADDRESS 8012 W 39th Kpho	
22c. DATE SIGNED 5-19-57		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MAY 16, 1957	
23c. NAME OF CEMETERY OR CREMATORY D.W. NEWCOMER'S SONS		23d. LOCATION (City, town, or county) KANSAS City		STATE Missouri	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		ADDRESS 1331 K.C. Ma BRUSH CREEK Blvd		25. DATE RECD. BY LOCAL REG. 5-16-57	
26. REGISTRAR'S SIGNATURE neva 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 causally related.

Daniel F. Hogan 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 *Rollie Kessel*

Licensed Embalmer No. *4690*
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.