

FILED JUN 7 1957

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 105

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 causally 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 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 Rural - Prairie Twp. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 50 Hi-Way & Colburn Rd. O | | Length of stay in lb | d. STREET ADDRESS 3526 Harrison | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Shirley Middle Sue Last English | | | 4. DATE OF DEATH May 23, 1957 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 Feb. 12, 1935 | 9. AGE (In years last birthday) 22 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer | | 10b. KIND OF BUSINESS OR INDUSTRY Hospital Supply | | 11. BIRTHPLACE (City and state or country) Lone Jack, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Hollis Yates | | | 14. MOTHER'S MAIDEN NAME Edith Markle | | |
| 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. 492-38-3116 | 17. INFORMANT Hollis Yates, RR 2, Kingsville, Mo. Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke & Hemorrhage resulting from crushing injury of chest, fractured cervical spine, fractured left femur | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) from crushing injury of chest, fractured cervical spine, fractured left femur | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 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.) car struck tree | | | |
| 20c. TIME OF INJURY Hour 7:30 Month May Day 23 Year 1957 a. m. p. m. | | | | | |
| 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.) 21st St. W | 20f. CITY, TOWN, OR LOCATION Jackson Mo | | |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22. SIGNATURE (Degree or title) Dr. C. L. ... | | | 22b. ADDRESS 6627 Market St | | 22c. DATE SIGNED 5-24-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 26, 1957 | 23c. NAME OF CEMETERY OR CREMATORY Lone Jack Cemetery | | 23d. LOCATION (City, town, or county) (State) Lone Jack, Missouri | |
| 24. FUNERAL DIRECTOR Langsford Funeral Home | | ADDRESS Lee's Summit, MO. | | 25. DATE RECD. BY LOCAL REG. 5-24-1957 | 26. REGISTRAR'S SIGNATURE M. G. Langsford |

AUG 16 1957

FEB 21 1958

JUN 4 1957

RECEIVED

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 *N. B. Langford*
Licensed Embalmer No. 496

P. O. Address Leeds Sur

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.