

Health,
Welfare
Public
Service

300
1-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 021041
STATE FILE NUMBER
2964

FILED JUL 12 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 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 (If NOT in hospital, give location) 7219 MAIN		Length of stay in lb 26 YEARS	d. STREET ADDRESS (If outside, give location) 7219 MAIN Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KATE Middle G Last Edmonds			4. DATE OF DEATH Month JUNE Day 23 Year 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 MARCH 12, 1867	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) PLATTE COUNTY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME HEMUEL T. OLIVER			14. MOTHER'S MAIDEN NAME FRANCES TURNER		
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. —	17. INFORMANT WALTER E EDMONDS (SON) 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) Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 10 min	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cardio Vascular Disease		4 yrs
	DUE TO (c) _____		4521
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 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 **Sept 14, 1957** to **June 23, 1957** and last saw her ^{her} ~~him~~ alive on **Mar 16, 1957**
Death occurred at **10:00 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Orval T. Needels M.D.	22b. ADDRESS 7400 Wornall St. No 14 Mo	22c. DATE SIGNED JUNE 23, 1957
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JUNE 27, 1957	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	23d. LOCATION (City, town, or county) (State) LAWRENCE KANSAS
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24. FUNERAL DIRECTOR ADDRESS D. W. NEACOMER'S SONS, KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 6-26-57	26. REGISTRAR'S SIGNATURE Neva Minshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Orval T. Needels

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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 em-
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Rollie Kessel

Licensed Embalmer No. 46

P. O. Address K.C.M.

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