

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

FILED JUL 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 021067
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2995

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1710 Summit</u>			Length of stay in lb <u>27yrs</u>		d. STREET ADDRESS (If outside, give location) <u>1710 Summit</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Delphine Garcia</u>				4. DATE OF DEATH <u>6-25-57</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-24-'28</u>					
9. AGE (In years last birthday) <u>28</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Wellington Kans</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Jose Garcia</u>				14. MOTHER'S MAIDEN NAME <u>Manuela Para</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no. and known) <u>No</u>			16. SOCIAL SECURITY NO. <u>"UNK"</u>		17. INFORMANT <u>Joe Garcia</u> Address <u>1710 Summit</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Tuberculosis?</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u>No Post Mortem</u>							INTERVAL BETWEEN ONSET AND DEATH <u>002X</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n). <u>Had influenza few days before death</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>				
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 <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>		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 alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Hugh H. Owens</u>				22b. ADDRESS <u>1034 Piatt Bldg</u>				22c. DATE SIGNED <u>6-27-57</u>			
23a. BURIAL OR REMOVAL (Specify)		23b. DATE <u>6-28-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>			23d. LOCATION (City, town, or county) (State) <u>ICC Mo.</u>				
24. FUNERAL DIRECTOR <u>B.E. Wulfe</u> ADDRESS <u>R.E. Mo</u>			25. DATE RECD. BY LOCAL REG. <u>6-28-57</u>		26. REGISTRAR'S SIGNATURE <u>Hava Minshall</u>						

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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 *Blaine E. Weiser*

Licensed Embalmer No. *40*
P. O. Address *U.S.*

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.