

Health, Welfare, Public Services
 300
 1-56
 ALL
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 Decatur, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Graham Asher

FILED JUN 28 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

57021080
 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2757

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 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 type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital | | | Length of stay in 1b 50 yrs. | d. STREET ADDRESS (If outside, give location) 8220 Walnut | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Grace Middle Pearl Last Greenhagen | | | | 4. DATE OF DEATH Month June Day 9 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 Oct. 20, 1897 | | 9. AGE (In years last birthday) 57 59 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins. 0 |
| 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) Grant City Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Douglas Porter | | | | 14. MOTHER'S MAIDEN NAME Mabel LaGrand | | | |
| 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. None | | 17. INFORMANT Address Lloyd Greenhagen 8020 Walnut K.C.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) Pulmonary Artery Embolization with Dissecting Aortic Aneurysm DUE TO (b) Thrombosis + Occlusion Inferior Vena Cava DUE TO (c) Metastases in Vena Cava by Sarcoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sarcoma of the Right Ovary involving Surrounding Tissues INTERVAL BETWEEN ONSET AND DEATH 2 minutes 2 weeks 2 weeks | | | | | | | |
| 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.) 175x | | | | | |
| 20c. TIME OF INJURY Hour 6-12 Month 12 Day 12 Year 1957 a. m. p. | | 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, etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from May 30 1957 to June 9 - 1957 and last saw her ^{alive} on June 9 - 1957 Death occurred at 6-12 p. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Graham Asher MD. | | | | 22b. ADDRESS 1220 Thompson Kansas City 6-mo. Mo. | | 22c. DATE SIGNED 6-10-57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE June 14-1957 | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | | 23d. LOCATION (City, town, or county) (State) Kansas City Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS Mrs. C.L. Forster Funeral Home Inc. K.C. Mo. | | | 25. DATE RECD. BY LOCAL REG. 6-12-57 | | 26. REGISTRAR'S SIGNATURE Neva Minshall | | |

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 V. Hendrick*

Licensed Embalmer No. 418

P. O. Address *P. O. Box 100*

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.