

Health,
Welfare
Public
Service

FILED JUL 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 02 1303
STATE FILE NUMBER
3044

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3044

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) Bennett Manor Inc.		d. STREET ADDRESS 805 W. 51 st.	
3. NAME OF DECEASED (Type or print) Ida May Righter		4. DATE OF DEATH Month June Day 30 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 Aug. 13, 1861
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home		11. BIRTHPLACE (City and state or country) Sommerville Ohio	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Richard H. Scott		13b. MOTHER'S MAIDEN NAME Nancy Pogue	14. NAME OF HUSBAND OR WIFE Wm. H. Righter (Dec.)
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 Richard S. Righter 805 W. 51 St. 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) 1 Hypertensive Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Gen. ant. Sclerosis + DUE TO (c) Laminitis			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 4500
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Washed decubitus ulcers			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 _____ a.m. _____ p.m. Month, Day, Year _____		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from 19 47 to 30 June '57 and last saw her alive on 30 June 57 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) Robert M. Myers M.D.		22b. ADDRESS 1025 Quail Bldg	22c. DATE SIGNED 1 July 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/1/57	23c. NAME OF CEMETERY OR CREMATORY Topeka Cemetery	23d. LOCATION (City, town, or county) (State) Topeka Kansas
24. FUNERAL DIRECTOR ADDRESS Stine & McClure K. C. Mo.		25. DATE RECD. BY LOCAL REG. 7-1-57	26. REGISTRAR'S SIGNATURE Neal Marshall

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Robert M. Myers

Country, Locality, etc. must be used only standard nomenclature in Part 10. No symptoms which are related. All diseases in Part I must be causally related.

KP
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in record
11/1/11

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 *J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *25 E. 2nd*

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.