

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57-021333  
STATE FILE NUMBER  
2583

FILED JUN 19 1957

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

300  
-57

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) <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 checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) <u>HOSPITAL OR INSTITUTION 4316 SUMMIT STREET</u>			Length of stay in 1b <u>50 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>2940 EAST 59TH STREET</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>J.</u> Last <u>SATTERWHITE</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC-30-1894</u>		9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>INTERNAL REVENUE DEPT.</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JAMES M. JACKSON</u>			13b. MOTHER'S MAIDEN NAME <u>ETTA REECE</u>		14. NAME OF HUSBAND OR WIFE <u>ORAL D. SATTERWHITE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>495-24-7124</u>		17. INFORMANT <u>ORAL D. SATTERWHITE</u> Address <u>2940 EAST 59TH STREET, KANSAS CITY, MISSOURI</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>Cachexia and Uremia</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Metastatic Carcinoma obstructing Ureters</u> <u>8 mo.</u> DUE TO (c) <u>Carcinoma of Cervix Uterus Stage III</u> <u>1 yr.</u>							PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>171X</u>		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 <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 <u>Sept 11 1956</u> , to <u>June 1, 1957</u> and last saw her alive on <u>June 1, 1957</u> Death occurred at <u>12:40 PM June 1, 1957</u> on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Dr. M. G. ... MD</u>					22b. ADDRESS <u>411 Nichols Rd</u>			22c. DATE SIGNED <u>6-1-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>6-4-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEMETERY</u>			23d. LOCATION (City, town, or County) (State) <u>KANSAS CITY MISSOURI</u>			
24. FUNERAL DIRECTOR <u>D.N. NEWCOMER'S SONS</u>			ADDRESS <u>331 BRUSH CREEK KANSAS CITY, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-1-57</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
John F. BOWSER

All diseases in Part I must be causally related.



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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KC Mo

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.