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All diseases in Part I must be causally related.

Glen H. Broyles

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 23 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 28235

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 3669

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3512 LOCUST ST. — Length of stay in 1b 2 WEEKS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY St. Louis
c. CITY OR TOWN UNIVERSITY CITY — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 730 HEMAN AVE. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First NORA Middle LEE Last FERDINAND

4. DATE OF DEATH Month AUG Day 2 Year 1957

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Nov. 21 - 1886
9. AGE (In years last birthday) 70 — 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) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and state or country) GIFFORD, ARK.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME CHARLES LANGFORD
13b. MOTHER'S MAIDEN NAME ANGELINE MARTIN
14. NAME OF HUSBAND ~~OR WIFE~~ —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 486-18-9078
17. INFORMANT MRS. WORTHAM D. JONES Address 3512 LOCUST K.C. MO

MEDICAL CERTIFICATION

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 Edema. Acute Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Thrombosis — 6 weeks
DUE TO (c) Ch. Hypertensive Cardio-Vascular Disease — Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 July 17 - '57, to Aug. 2 - 57 and last saw her/him alive on Aug. 2 - 1957
Death occurred at 11:10 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Glen H. Broyles (Degree or title) M.D.
22b. ADDRESS 1232 Professional Bldg
22c. DATE SIGNED Aug 3 - '57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 8-5-57
23c. NAME OF CEMETERY OR ~~CREMATORY~~ MT. MORIAH CEM.
23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI

24. FUNERAL DIRECTOR D W NEWCOMER'S SONS ADDRESS 1331 BRUSH CREEK KANSAS CITY MO
25. DATE RECD. BY LOCAL REG. 8-5-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Vern Lawler

Licensed Embalmer No. 4915

P. O. Address 47 E 32nd

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