

STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1957

288301  
STATE FILE NUMBER 3685

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 3685

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| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>TOWN <b>KANSAS CITY</b> |  | c. CITY OR TOWN <b>KANSAS CITY</b>   |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. MARY'S Hospital</b>                   |  | d. STREET ADDRESS (If outside, give location) <b>1009 EAST 26th ST.</b>  |  |
| Length of stay in 1b <b>46 YRS</b>   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

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|---|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MAUDE</b> Middle Last <b>MANNYPENNY</b> |  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>4</b> Year <b>1957</b> |  |  |  |
|---|--|--|---|--|--|--|

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|----------------------|-------------------------------|---|---------------------------------------|---|---|--------------------------------|
| 5. SEX <b>FEMALE</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>MARCH 1, 1881</b> | 9. AGE (In years last birthday) <b>76</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|---|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>HOUSEWIFE</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <b>Fontana, Kansas</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
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| 13a. FATHER'S NAME <b>Joseph Surber</b> | 13b. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b> | 14. NAME OF HUSBAND OR WIFE <b>ALBERT W. MANNYPENNY</b> |
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|   |                                     |                                       |   |
|---|-------------------------------------|---------------------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>NONE</b> | INFORMANT <b>ALBERT W. MANNYPENNY</b> | Address <b>K.C. Mo. 1009 E 26th St.</b> |
|---|-------------------------------------|---------------------------------------|---|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> |   | INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>arterio-sclerotic Heart Dis</b> | <b>7 years</b>                                  |
|   | DUE TO (c)                                    | <b>4200</b>                                     |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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.) |
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|---|--|--|---|
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. | 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 |
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| 21. I attended the deceased from <b>7-24-57</b> to <b>8-4-57</b> and last saw her alive on <b>8-4-57</b><br>Death occurred at <b>4:31 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |
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|---|--------------------------------|--------------------------------|
| 22a. SIGNATURE (Degree or title) <b>Hubert M. Parker M.D.</b> | 22b. ADDRESS <b>928 Argyle</b> | 22c. DATE SIGNED <b>8-5-57</b> |
|---|--------------------------------|--------------------------------|

|   |                   |                                    |   |
|---|-------------------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) | 23b. DATE         | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
| <b>CREMATION</b>                              | <b>AUG-6-1957</b> | <b>D.W. NEWCOMER SONS</b>          | <b>KANSAS CITY, MISSOURI</b>                  |

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 24. FUNERAL DIRECTOR <b>D.W. NEWCOMER SONS</b> | ADDRESS <b>1331 BRUSH CREEK BLVD</b> | 25. DATE RECD. BY LOCAL REG. <b>8-6-57</b> | 26. REGISTRAR'S SIGNATURE <b>new Marshall</b> |
|--|--------------------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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. — *Remains Not Embalmed* —

Student .....  
Signature of Student Embalmer

Signed *Rollie Kessel* .....

Licensed Embalmer No. *4690* .....  
P. O. Address *K.C. 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.