

Health, Welfare, Public Service

FILED SEP 16 1957

STANDARD CERTIFICATE OF DEATH

31761

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3817

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE Kansas b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS 5617 Aberdeen Road	
3. NAME OF DECEASED (Type or print) First EVERETT Middle D. Last CARTER		4. DATE OF DEATH Month August Day 14 Year 1957	
5. SEX Male	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 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk-Circuit Court & Grocery		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME R. P. Carter		13b. MOTHER'S MAIDEN NAME Louella Douglas	14. NAME OF HUSBAND OR WIFE Pearl Carter
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. 513-14-1154A	17. INFORMANT Address Mrs. Jack Clifford, 5617 Aberdeen Road
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma metastatic DUE TO (c) Carcinoma of Sigmoid			INTERVAL BETWEEN ONSET AND DEATH 7-8 months 10-12 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153x			
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 WORK <input type="checkbox"/> 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 Jan 1957 to Aug 14 57 and last saw her alive on Aug 14 1957 Death occurred at 11:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. Schultz (Degree or title) M.D.		22b. ADDRESS 0 330 W. 47th St., Kansas City, Mo.	22c. DATE SIGNED 8/15/1957
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 15, 1957	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Windsor Missouri
24. FUNERAL DIRECTOR ADDRESS D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 8-15-57	26. REGISTRAR'S SIGNATURE neva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

C. B. Schutz



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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *47 E 32 Rd*

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.