

Health,
Welfare
Public
Service

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ALL DEATHS, CAUSES OF DEATH, AND MANNER OF DEATH MUST BE LISTED. NO SYMPTOMS WILL BE LISTED. ALL DEATHS, CAUSES OF DEATH, AND MANNER OF DEATH MUST BE LISTED. NO SYMPTOMS WILL BE LISTED. ALL DEATHS, CAUSES OF DEATH, AND MANNER OF DEATH MUST BE LISTED. NO SYMPTOMS WILL BE LISTED.

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31769
STATE FILE NUMBER
4078
REGISTRAR'S NO.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5045 Wabash		Length of stay in 1b 34 Yrs	d. STREET ADDRESS (If outside, give location) 5045 Wabash Reside on Farm <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Alberta Middle Larue Last Clardy			4. DATE OF DEATH Month 8 Day 31 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-12-1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 5 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Callaway Co. Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Joseph Emmons			14. MOTHER'S MAIDEN NAME Martha Holt			
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 E. Barton Donaldson 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) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH 20 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterial sclerosis</u>	15 yrs.
	DUE TO (c) <u>Ages</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</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 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 <u>Kansas City, Jackson - Mo.</u>

21. I attended the deceased from <u>1935</u> to <u>8-31-57</u> and last saw her alive on <u>8-31-57</u> Death occurred at <u>5:20</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>A. E. Linville</u> (Degree or title)	22b. ADDRESS <u>25-E-12th-N.E.-6-Mo.</u>	22c. DATE SIGNED <u>8-31-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE: 9-3-57	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Freeman Mortuary K.C. MO.		25. DATE RECD. BY LOCAL REG. 9-1-57	26. REGISTRAR'S SIGNATURE <u>Elva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
A. E. Linville D. O. I.

MEDICAL CERTIFICATION

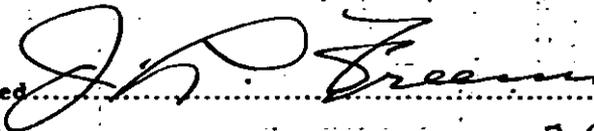
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{Dr. of} en

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 29

P. O. Address K. C. 1

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