

Health,
Welfare
Public
Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31808
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4249

FILED OCT 4 1957

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) KANSAS City		c. CITY OR TOWN KANSAS City	
c. FULL NAME OF (If NOT in hospital, give location) ST. MARY'S Hospital		d. STREET ADDRESS 3715 ASKEWAVE	
3. NAME OF DECEASED (Type or print) Raymond E. Diehm		4. DATE OF DEATH Month Day Year SEPT. 10, 1957	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 11, 1886
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FIREMAN		11. BIRTHPLACE (City and state or country) FONTANA, KANSAS	
13a. FATHER'S NAME JACOB F. DIEHM		14. NAME OF HUSBAND OR WIFE JESSIE M. DIEHM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT MRS JESSIE M. DIEHM	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Left motor area		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 Death occurred at 9-3-57 to 9-10-57 and last saw her alive on 9-10-57		22a. SIGNATURE Dr. W.P. Miller M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT. 12, 1957	
23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY - MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMERSONS		25. DATE RECD. BY LOCAL REG. 9-12-57	
26. REGISTRAR'S SIGNATURE New Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

W.P. MILLER

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 Adrian Jay Stitt

Licensed Embalmer No. 4892

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.