

Health,
Public
Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31811
STATE FILE NUMBER
3938

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

300 D
1-57

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		Length of stay in lb 35 yrs	d. STREET ADDRESS (If outside, give location) 1106 Michigan
3. NAME OF DECEASED (Type or print) Commilia			4. DATE OF DEATH Month Day Year August 20, 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10th, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 63
13a. FATHER'S NAME John Connors		13b. MOTHER'S MAIDEN NAME unknown	12. CITIZEN OF WHAT COUNTRY? U S A
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	14. NAME OF HUSBAND OR WIFE Fern Dodd
17. INFORMANT Percy Dodd, son			Address 1414 Brooklyn
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure			INTERVAL BETWEEN ONSET AND DEATH 4341
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
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"/>
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 7-26-57 to 8-20-57 and last saw her alive on 8-20-57 Death occurred at 10:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W.R. Peterson MD		22b. ADDRESS 600 E. 22nd Street	22c. DATE SIGNED 8-22-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug 24th 1957	23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Adkins Funeral Home		ADDRESS 2000 E 12th St.	25. DATE RECD. BY LOCAL REG. 8-22-57
26. REGISTRAR'S SIGNATURE Neve Marshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
W.R. Peterson

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.

Student
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. *[Handwritten Number]*
P. O. Address *[Handwritten Address]*

**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.**