

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31816

STATE FILE NUMBER

FILED SEP 16 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3838

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Walnut Nursing Home</u>			Length of stay in it <u>75 yrs</u>		d. STREET ADDRESS <u>3522 Walnut</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>G.</u> Last <u>DREES</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15, 1882</u>		9. AGE (In years last birthday) <u>75</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Ferdinand Drees</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jakobe</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Anne Drees - 4007 Harrison</u>				
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>Pneumonia &amp; Uremia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Carcinomatosis, Generalized</u>		DUE TO (c) <u>Carcinoma of Prostate</u>		4 mos.		Not known	
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 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	
21. I attended the deceased from <u>June 2, 1957</u> to <u>9 Aug. 57</u> and last saw her alive on <u>4 Aug. 57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Type or print) <u>Wallace H. Graham, M.D.</u>					22b. ADDRESS <u>518 Argyle Bldg. K.C. Mo</u>		22c. DATE SIGNED <u>16 Aug 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial &amp; Removal</u>		23b. DATE <u>8-17-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Kansas</u>		(State)	
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar Funeral Home</u>				ADDRESS <u>1800 E. Linwood, K. C., MO</u>		25. DATE RECD. BY LOCAL REG. <u>8-16-57</u>		26. REGISTRAR'S SIGNATURE <u>New Marshall</u>	

Wallace H. Graham

Dr. Wallace H. Grant  
Angyle Bldg.

No 1-0111

12-5 P.M. - FRI.



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 James E. Kach

Licensed Embalmer No. 45

P. O. Address K.C.

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.