

Health,
Welfare
Public
Service

300
1-57

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31820

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4188

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 type="checkbox"/>		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1641 Belleview		Length of stay in lb 45 yrs.		d. STREET ADDRESS (If outside, give location) 1641 Belleview	
3. NAME OF DECEASED (Type or print) First MINNIE Middle MAY Last DUER			4. DATE OF DEATH Month 9 Day 6 Year 1957		
5. SEX Female	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 5/5/1885	9. AGE (In years (birthday)) 72	IF UNDER 1 YEAR Months 4 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sedalia, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME Chris Rutherford		13b. MOTHER'S MAIDEN NAME Lizzie Strater		14. NAME OF HUSBAND OR WIFE dra E. Duer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and date of service) No		16. SOCIAL SECURITY NO. 496-09-3531		17. INFORMANT Address Joseph Mall - 4445 Fisher, Kansas City, Ks.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Livers - Esophageal veins				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)				5810	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus				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 8-1-55 to 9-6-57 and last saw ^{her} alive on 9-6-57 Death occurred at 11:57 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Martin J. Mueller M.D.			22b. ADDRESS 535 Angyle Bldg K.C.Mo		22c. DATE SIGNED 9-6-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/9/1957		23c. NAME OF CEMETERY OR CREMATORY Floral Hills Memorial Garden	
				23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels K.C.Mo.			25. DATE RECD. BY LOCAL REG. 9-7-57		26. REGISTRAR'S SIGNATURE Mrs. Marshall

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Martin J. Mueller

All diseases in Part I must be causally related.

*Dr. William J. Mueller
8227
W. McQueen
over Kutz*

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
TALLAHASSEE, FLORIDA

DATE OF DEATH: MAY 19 1938
PLACE OF DEATH: WHITE
SEX: MALE
RACE: WHITE
AGE: 21

Signature of Licensed Embalmer: [Signature]
Signature of Student Embalmer: [Signature]

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 *W. J. Mueller*
Licensed Embalmer No. *3938*
P. O. Address *A. C. Mc*

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.

