

Please use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1957

31895

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar No. 4173

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Westport N.Home</b>			Length of stay in lbs <b>6 yrs</b>	d. STREET ADDRESS <b>5218 Indiana</b> (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>E.</b> Last <b>HARKNESS</b>				4. DATE OF DEATH Month <b>9</b> Day <b>5</b> Year <b>57</b>				
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-31-1896</b>		9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>No Record</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ann Poling</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No XX</b>			16. SOCIAL SECURITY NO. <b>497-36-1861</b>		17. INFORMANT Address <b>Mrs. Geo. Harkness, 2406 Denver, KC Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>Mitral regurgitation</b> 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) <b>Senile</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 yrs.</b> <b>3-4 yrs.</b> <b>410x</b>	
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 _____ 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 <b>1956</b> to <b>Sept. 5, 1957</b> and last saw her alive on <b>Sept 3, 1957</b> Death occurred at <b>2:00 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>James W. Graham M. D.</b>				22b. ADDRESS <b>518 Argyle Bldg.</b>		22c. DATE SIGNED <b>9/6/57</b>		
23a. BURIAL, CREMATION, RENOVATION (Specify) <b>Burial</b>		23b. DATE <b>9-7-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home, K C Mo</b>				25. DATE RECD. BY LOCAL REG. <b>9-6-57</b>		26. REGISTRAR'S SIGNATURE <b>Irene Minshall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

James W. Graham

1:00 P.M.  
7/14 1-5676



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 *Alvin R. Haunschild*

Licensed Embalmer No. *41*

P. O. Address *B. 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.