

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1957

31907
STATE FILE NUMBER
4115

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN NORTH KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION OSTEOPATHIC HOSPITAL		d. STREET ADDRESS (If outside, give location) 1001 E 25th AVENUE	
3. NAME OF DECEASED (Type or print) KATE		4. DATE OF DEATH August 31 - 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 OCT-29-1874	
9. AGE (In years birth day) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - AT HOME	
11. BIRTHPLACE (City and state or country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME CHARLES MANKEMEYER		13b. MOTHER'S MAIDEN NAME CATHERINE WANDER	
14. NAME OF HUSBAND OR WIFE JAMES HAYS		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		17. INFORMANT HOSPITAL RECORDS 11th + HARRISON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial failure DUE TO (b) cardiac decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Normal 3 wks? 4343
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 5pm 8-30-57 to death and last saw her alive on 8-30-57 Death occurred at 12:40 A. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. DATE SIGNED 8-31-57	
22b. SIGNATURE (Degree or title) 2 Wm. R. Morrison, D.O.		22c. ADDRESS 2014 Swift, N.K.C., Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE SEPT. 3-1957	
23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 9-3-57	
26. REGISTRAR'S SIGNATURE new Minshall			

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.
Wm. R. Morrison

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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 *Raymond M. Hardy*

Licensed Embalmer No. *4913*
P. O. Address *Indep., 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.