

Health, Welfare & Public Service

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
4250

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

300 0
-57

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 mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City mo.</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>Lakeside Hospital</u>		Length of stay in 1b <u>37 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>1301 Fremont</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Gladys</u> Last <u>Helms</u>			4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 17, 1912</u>		9. AGE (In years) <u>45</u> F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Mr Robert Mulaid</u>		13b. MOTHER'S MAIDEN NAME <u>LAURAD ufore</u>		14. NAME OF HUSBAND OR WIFE <u>Albert Helms Sr</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>488-32-9704</u>		17. INFORMANT <u>Barbara Helms</u> Address <u>Kansas City mo.</u> <u>1301 Fremont</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>Peritonitis due to Duodenal Perforation + Mechanical Obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>3 mos</u> <u>5411</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUO TO (b) <u>Duodeny + Pre Pyloric Uicer</u>		
	DUO TO (c) <u>with subtotal Gastrectomy</u>		
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 g.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
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21. I attended the deceased from MAY 1957 to SEPT 10-57 and last saw her alive on SEPT-10-57
Death occurred at 3:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wm. Craggthy D.O.</u>	(Degree or title)	22b. ADDRESS <u>5811 Trumond Rd K.C.</u>	22c. DATE SIGNED <u>9/16/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT-12-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>P.W. NEWCOMER'S SONS</u>		ADDRESS <u>1331 BOUSH CREEK N. C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-12-57</u>
			26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
W. M. Craggthy

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 *Raymond M. Hardy*

Licensed Embalmer No. *4913*

P. O. Address *Indap, M*

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.