

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31918

STATE FILE NUMBER

4138

FILED SEP 24 1957

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Blue Springs</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukia Hospital 1800 S. Main</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>R.R. #2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Est</u> Last <u>HESKETT</u>				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>57</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>9/3/57 2:15 am</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours <u>18</u> Min. <u>30</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Kansas City Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>1</u>		
13. FATHER'S NAME <u>William Franklin Heskett</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Irene McWilliams</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Blue Springs, R.R. #2 William F. Heskett</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</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aspiration Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u> <u>7635</u>		
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>Sept 2, 1957</u> to <u>Sept 3, 1957</u> and last saw <u>her</u> <u>him</u> alive on <u>Sept 3, 1957</u> . Death occurred at <u>840 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>William F. Bell M.D.</u>				22b. ADDRESS <u>Lee's Summit, Mo</u>		22c. DATE SIGNED <u>9-4-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9/5/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Alta Vista</u>		23d. LOCATION (City, town, or county) (State) <u>Alta Vista Kas.</u>				
24. FUNERAL DIRECTOR <u>Stone & McElure R. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-4-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

William F. Bell

R.A. - Bz - 1-1593

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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 *F. S. Walter*

Licensed Embalmer No. 27

P. O. Address *N.C.M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitute's 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.