

FILED OCT 9 1957

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
31924  
4337

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

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		Jackson		a. STATE		Missouri	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Inside Limits OR TOWN Kansas City,		b. COUNTY		Jackson	
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN		Kansas City,	
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		4423 Roanoke Pk. Way	
c. FULL NAME OF HOSPITAL OR INSTITUTION		3240 Norledge		Length of stay in lb		75 yrs	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Last		Month Day Year	
Flora		Lottie		Hitchler		Sept. 16 1957	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 11 1874		83	
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)	
Housewife						Indiana USA	
12. CITIZEN OF WHAT COUNTRY?				12. CITIZEN OF WHAT COUNTRY?			
USA				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Owen Fisher				Unknown			
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 Address			
No		None		Harold Hitchler (son) 7432 Penn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral vascular thrombosis							2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Cerebral arteriosclerosis							
DUE TO (c)							332 x
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 Month, Day, Year							
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	
				Kansas City, Missouri		Jackson Mo	
21. I attended the deceased from Jan 1956 to Sept 16, 1957 and last saw her alive on Sept 10, 1957. Death occurred at 7:30 p. p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
K. L. Shireman M.D.				4606 St. John Kansas		9-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Sept 18 1957		Memorial Park		Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Mrs C.L. Forster Funeral Home Inc.				9-18-57		Neva Minshall	
Kansas City, Missouri.				(Licensed Embalmer's Statement on Reverse Side)			

300  
1-56

health, Welfare Public Service

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

K. L. Shireman

MEDICAL CERTIFICATION



1000001

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 *J. Daniel Harris* .....  
Licensed Embalmer No. 35

P. O. Address *R.C.M.* .....

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.