

Health,
Welfare
Public
Service

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31933
STATE FILE NUMBER
4251

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300
-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) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <u>27320 E. 27th St.</u>		Length of stay in lb <u>39 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4320 E. 27th</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Barnett</u> Last <u>Howe</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</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>Feb-10-1878</u>	9. AGE (In years) Months <u>77</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. OLD BUSINESS OR INDUSTRY <u>Benson Mfg. Co.</u>		10c. CITY AND STATE OF BIRTH <u>Clinton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>H.W. Howe</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha May Howe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give branch, service, dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-03-4044A</u>		17. INFORMANT Name <u>Anna L. Seever</u> Address <u>1305 Agnes K.C. Mo.</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>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						4201	
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 _____ 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>Jan. 1954</u> to <u>Aug 27, 1957</u> and last saw her ^{her} alive on <u>Aug 27, 1957</u> Death occurred at <u>Sept 10, 1957 7:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Kenneth Adler, D.O.</u>				22b. ADDRESS <u>5811 Truman Rd.</u>		22c. DATE SIGNED <u>9-11-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Sept-13-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clinton, Missouri</u>	
24. FUNERAL DIRECTOR <u>C.H. Blackman & Son Inc.</u> ADDRESS <u>K.C., Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-12-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Kenneth Adler

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

KP
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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 Bert B. Benne

Licensed Embalmer No. 4656
P. O. Address H. C. 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.

Dr. Adkin
Blen Valley Clinic