

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32029

STATE FILE NUMBER

4009

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4009

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Jackson County</u>				a. STATE <u>Kansas</u>		b. COUNTY <u>Ottawa</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>Minneapolis</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>Trinity Lutheran.</u>			Length of stay in lb <u>1 MONTH</u>		X d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. SEX		
First <u>Stella</u>		Middle		Last <u>Markley</u>		Month <u>Aug</u> Day <u>26</u> Year <u>57</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/8/1886</u>		
9. AGE (In years last birthday) <u>70</u>		IF 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>Oshorn, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Norman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Baldwin</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>510-32-5074</u>		17. INFORMANT <u>Lester L. Markley</u> Address <u>Grandview Mo. 13400 Byars Road</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>Terminal Bronchial Pneumonia</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>4201</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 checked="" type="checkbox"/> NO <input 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 _____ 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>8/23/57</u> to <u>8/26/57</u> and last saw her alive on <u>8/26/57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. W. Young M. D.</u>				22b. ADDRESS <u>1401 S. W. Blvd KCMO</u>		22c. DATE SIGNED <u>8/27/57</u>		
23a. URN, CREMATION REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8-27-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Minneapolis Kansas</u>		23d. LOCATION (City, town, or county) (State) <u>Minneapolis, Kans.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>P. A. Fulton 18th &amp; Washington</u>				25. DATE RECD BY LOCAL REG. <u>8-27-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. W. Young

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All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.



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 Ralph Fultz \_\_\_\_\_

Licensed Embalmer No. 30

P. O. Address H.C.

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.