

FILED OCT 9 1957

Registration District No. 149 Primary Registration District No. 1002

300
1-57 4

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson						
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Haven Manor Rest Home			Length of stay in lb 42yrs		d. STREET ADDRESS 3526 Walnut		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grace				First Maupin		Last		4. DATE OF DEATH Month 9 Day 18 Year 57		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-8-1907		9. AGE (In years last birthday) 47		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Davis County Missouri		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Frank B. Worthen			13b. MOTHER'S MAIDEN NAME Nancy Elizabeth Lambert			14. NAME OF HUSBAND OR WIFE Unk				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. none		17. INFORMANT Dale B. Maupin 5295 Lydia				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Heart Failure Interventricular Septal Defect Ren Arteriosclerosis DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1200			
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 <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 Kansas City		COUNTY Jackson		STATE	
21. I attended the deceased from Feb 1956 , to Sept 18 1957 and last saw her alive on Sept 18 1957 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) Jack B. Brams M.D.					22b. ADDRESS 1103 Grand Ave			22c. DATE SIGNED 9/20-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-20-57		23c. NAME OF CEMETERY OR CREMATORY Chapel Hill			23d. LOCATION (City, town, or county) (State) Kansas City Kansas			
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo				ADDRESS		25. DATE RECD. BY LOCAL REG. 9-20-57		26. REGISTRAR'S SIGNATURE Neva Marshall		

All diseases in Part I must be causally related.

Jack B. Brams M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



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 Richard E. Carroll

Licensed Embalmer No. 4849

P. O. Address K.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.