

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 19 1957

STATE FILE NUMBER **32069**  
REGISTRAR'S NO. **4013**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Prairie Village</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's</b>		Length of stay in 1b <b>10 days</b>	d. STREET ADDRESS <b>4906 W. 72 Terrace</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b></b> Last <b>Newburger</b>			4. DATE OF DEATH Month <b>8-</b> Day <b>25-</b> Year <b>57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <del>WIDOW</del> <del>XXX</del> <del>WIDOW</del> <del>XXX</del>	8. DATE OF BIRTH <b>Sept. 10, 1878</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Oshkosh, Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Henry F. Myers</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Yagers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>Sidney Newburger Jr.</b> Address <b>Prairie Village Kansas</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Cerebral thrombosis</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> 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) <b>3324</b>					INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>5 days</b> <b>Unknown</b>
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 <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>					
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 <b>August 19, 1957</b> to <b>August 25, 1957</b> and last saw <sup>her</sup> <del>him</del> alive on <b>August 25, 1957</b> . Death occurred at <b>7:00 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Chester F. Fee, M.D.</b>			22b. ADDRESS <b>8023 Santa Fe Drive Overland Park, Kansas</b>		22c. DATE SIGNED <b>August 26, 1957</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-27-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johnson Co. Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Johnson Co. Kansas</b>
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>		ADDRESS <b>K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-27-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

Health, Welfare, Public Service  
300-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. AT  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Chester F. Fee



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 *Walter H. Erwin*.....

Licensed Embalmer No. *43*

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.