

FILED SEP 19 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4041

300
1-57

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) TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>323 S. White</u>		d. STREET ADDRESS (If outside, give location) <u>323 S. White</u>	
Length of stay in lb <u>25 yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>GLENN A</u> Middle <u>M.</u> Last <u>PINE</u>			4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>57</u>			
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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>7/13/1883</u>	9. AGE (In years last birthday) <u>74</u>	10. F UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
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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>Hickory Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William H. Young</u>	13b. MOTHER'S MAIDEN NAME <u>Susie MYERS</u>	14. NAME OF HUSBAND OR WIFE <u>Squire Jim PINE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>NORA E. Jones</u>	Address <u>324 S. BELLAIRE</u>
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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>minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary atherosclerosis</u>		<u>over 2 years</u>
	DUE TO (c) <u>diabetic mellitus</u>		<u>100X many years</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? 2 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.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
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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	COUNTY _____ STATE _____
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21. I attended the deceased from <u>5-7-55</u> to <u>8-27-57</u> and last saw her alive on <u>8-24-57</u> Death occurred at <u>11:00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wilson H. Miller M.D.</u>	22b. ADDRESS <u>4630 Independence Ave Kansas City Mo</u>	22c. DATE SIGNED <u>8-28-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-31-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u>	ADDRESS <u>Kcmo</u>	25. DATE RECD. BY LOCAL REG. <u>8-29-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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WILSON H. MILLER USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. Doxary, coronar, etc. must use only standard nomenclature in item 18. No symptoms will be listed.



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. *4879*

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.