

Health,  
Welfare  
Public  
Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32618  
STATE FILE NUMBER  
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4073

300  
1-57

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY JACKSON |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>KANSAS CITY   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN KANSAS CITY  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 2205 Forest   |  | Length of stay in 1b<br>35  | d. STREET ADDRESS (If outside, give location)<br>2205 Forest   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First MARY Middle WILLIE Last TISBY   |  |   | 4. DATE OF DEATH<br>Month August Day 29 Year 1957  |   |   |
| 5. SEX<br>Female <sup>3</sup>  | 6. COLOR OR RACE<br>N <sup>o</sup> gro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Feb. 25, 1886  | 9. AGE (In years last birthday) 71 yrs. 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)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Fayette, Missouri  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 13a. FATHER'S NAME<br>Unknown  |  | 13b. MOTHER'S MAIDEN NAME<br>Winnie Stapleton   |  | 14. NAME OF HUSBAND OR WIFE<br>Fred Tisby   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT Address<br>Irene Washington 2011, Flora Sister   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Edema<br>DUE TO (b) Myocardial Insufficiency<br>DUE TO (c) Arteriosclerosis<br>Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>4221  |
| 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<br>Hour Month, Day, Year<br>a.m.<br>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 _____, to _____ and last saw her alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |  |   |   |
| 22a. SIGNATURE<br>Deputy Coroner   |  |   | 22b. ADDRESS<br>1618 Lydia Ave   |   | 22c. DATE SIGNED<br>8/31/57   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 23b. DATE<br>Sept. 1, 1957             | 23c. NAME OF CEMETERY OR CREMATORY<br>Lexington, Missouri   |  | 23d. LOCATION (City, town, or county)<br>Lexington, Mo.   |   |
| 24. FUNERAL DIRECTOR<br>Watkins Brothers Fn. Hm. 18th & Benton   |  |   | 25. DATE RECD. BY LOCAL REG.<br>8-31-57  | 26. REGISTRAR'S SIGNATURE<br>Irene Marshall   |   |

L. M. Tillman USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Drew R. Watkins* .....

Licensed Embalmer No. *75W* .....  
P. O. Address *18th & Be* .....

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.