

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32227

STATE FILE NUMBER

4451

FILED OCT 9 1957

Registration District No. 149 Primary Registration District No. 1007 Registrar's No.

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

H. O. Pence

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) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Northeast Hosp.		Length of stay in 1b 5 hrs.	d. STREET ADDRESS 1235 West South Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSIAH E. VAN ARTSDALEN			4. DATE OF DEATH Sept. 24, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1886		9. AGE (In years last birthday) 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Turner		10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel		11. BIRTHPLACE (City and state or country) Marshalltown, Iowa	
13. FATHER'S NAME Silas William Van Artsdalen			14. MOTHER'S MAIDEN NAME Laura A. Wescott		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 487-05-4577		17. INFORMANT 1235 W. So. Ave., Indep., Mo. Mrs. Nellie M. Van Artsdalen,	
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 apoplexy Apoplexy					INTERVAL BETWEEN ONSET AND DEATH 3 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Arterio-sclerosis					?
DUE TO (c) Hypertension					33 1/2
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 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.)		
20c. TIME OF INJURY Hour, Month, Day, Year 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 Sept 20-57 to Sept 24 57 and last saw him alive on 9/24/57 Death occurred at 5:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) H. O. Pence D.O.			22b. ADDRESS 2722 Prospect KC. Mo		22c. DATE SIGNED 9/24/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 24, 1957		23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	
				23d. LOCATION (City, town, or county) (State) Independence, Missouri	
24. FUNERAL DIRECTOR George C. Carson, Independence, Mo.			25. DATE RECD. BY LOCAL REG. 9-24-57		26. REGISTRAR'S SIGNATURE Neva Marshall

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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 *C. Ray Landerbach*
Licensed Embalmer No. 50

P. O. Address *Indep.,*

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.