

Health,
& Welfare
Public
Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32259
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4017

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) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2601 E. 12th St.</u>		Length of stay in lb <u>12 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>2720 E. 12th St.</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>JAY</u> Last <u>WIDMAYER</u>			4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>57</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/23/1912</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____	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>COOK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE OHIO P.P.</u>	11. BIRTHPLACE (City and state or country) <u>NAPPANEE IOWA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>No Record</u>	13b. MOTHER'S MAIDEN NAME <u>No Record</u>	14. NAME OF HUSBAND OR WIFE <u>No Record</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Louise DAVIS</u> Address <u>2720 E. 12th St.</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>Cause of Septicemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7955</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause test. DUE TO (b) _____ DUE TO (c) _____		
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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. 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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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____
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) <u>R. W. Kealhofer, M.D., Deputy Coroner</u>	22b. ADDRESS <u>6627 Washburn St</u>	22c. DATE SIGNED <u>8-29-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/29/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NAPPANEE IOWA</u>	23d. LOCATION (City, town, or county) (State) <u>NAPPANEE IOWA</u>
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24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u>	ADDRESS <u>505 E. 12th St.</u>	25. DATE RECD. BY LOCAL REG. <u>8-29-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Richard E. Carroll*

Licensed Embalmer No. *4827*

P. O. Address *H. C. Sues*

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.