

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35855

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4670

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>Downtown Hospital</u>		Length of stay in 1b <u>About 30yrs.</u>	d. STREET ADDRESS <u>1402 Tracy</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRMA C. HARRIS</u>			4. DATE OF DEATH Month Day Year <u>October 6, 1957</u>		
5. SEX <u>3</u> <u>Female</u>	6. COLOR OR RACE <u>Negro</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>Aug. 7, 1897</u>	9. AGE (In years last birthday) <u>60</u>	IF UNDER 1 YEAR Months Days <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Families</u>	11. BIRTHPLACE (City and state or country) <u>Webbska Ark.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Clay</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine</u>	14. NAME OF HUSBAND OR WIFE <u>Judge D. Harris</u>		
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>499-14-3594</u>	17. INFORMANT Address <u>Judge D. Anderson - 1402 Tracy</u>			
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>Myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Failure</u>					
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>					<u>4200</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? 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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>5-9-56</u> to <u>10-6-57</u> and last saw her alive on <u>10-5-57</u> Death occurred at <u>1 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. Robert Negro</u> (Deceased or title)			22b. ADDRESS <u>1222 McGee St., K.C., Mo.</u>		22c. DATE SIGNED <u>10-7-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
24. FUNERAL DIRECTOR <u>Walter Dean F. H.</u>		ADDRESS <u>1212 Vine St.</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Deva Minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

E. Robert Negro USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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

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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



Licensed Embalmer No. 3178.....

P. O. Address, 1212 Vine St., Kans

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.