Health, Welfare Public Service

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1-56

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 35891

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4729

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center — Length of stay in 1b Since 1941

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS 3429 E. 6th (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Hazel Middle Last Holt

4. DATE OF DEATH Month Day Year October 13, 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 1, 1914
9. AGE (In years last birthday) 43 — 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) housewife
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (City and state or country) Marshall, Mo
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Fluis Osborn
14. MOTHER'S MAIDEN NAME Susie Hillen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 487-09-7065
17. INFORMANT Address Jack Holt, K.C. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Hypertension — year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Alimentary Nephritis Chronic — year
DUE TO (c) — 592X

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 ☐ NO ☑ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9/13/57, to 10/13/57 and last saw her/him alive on 10/13/57
Death occurred at 10 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul Moss (Degree or title) M.D.
22b. ADDRESS 406 Bryant Bld
22c. DATE SIGNED 10/13/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 10-13-57
23c. NAME OF CEMETERY OR CREMATORY —
23d. LOCATION (City, town, or county) (State) Marshall Mo

24. FUNERAL DIRECTOR Sweeney Mortuary ADDRESS Marshall Mo
25. DATE RECD. BY LOCAL REG. 10-13-57
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

KP 2

JUL 17 1962

APR 3 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed John R. Sudm

Licensed Embalmer No. 4 5

P. O. Address Kansas C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.