

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35906

STATE FILE NUMBER

FILED OCT 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4570

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Ray</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Lawson</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Research Hospital</i>			Length of stay in 1b <i>2 days</i>		d. STREET ADDRESS (If outside, give location) <i>3 1/2 mi. n.e.</i>
3. NAME OF DECEASED (Type or print) First <i>NORA</i> Middle Last <i>HUNT</i>			4. DATE OF DEATH Month <i>Sept.</i> Day <i>29</i> Year <i>1957</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 19, 1885</i>	9. AGE (In years last birthday) <i>71</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Polo, Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>
13. FATHER'S NAME <i>Amos Knutler</i>			14. MOTHER'S MAIDEN NAME <i>Lucinda Cummings</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>491-20-2150</i>		17. INFORMANT <i>Arthur A. Hunt Lawson, Mo.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i>					INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>degenerative heart failure</i>					<i>1 mo.</i>
DUE TO (c) <i>Branch - pneumonia</i>					<i>19th</i>
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 <i>9/27/57</i> to <i>9/29/57</i> and last saw her ^{her} _{alive} on <i>9/29/57</i> 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) <i>Dr. R. C. McClanahan M.D.</i>			22b. ADDRESS <i>820 Professional Bldg.</i>		22c. DATE SIGNED <i>10/2/57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>10/1-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lawson Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Lawson, Mo.</i>
24. FUNERAL DIRECTOR <i>Pritchard Funeral Home</i>		ADDRESS <i>Excelsior Home Springs Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>10-2-57</i>	26. REGISTRAR'S SIGNATURE <i>neva Minshall</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Robert C. Mc Clanahan

Dr. Robert C. McClanahan
Prof. Bldg.
GR 1-2892

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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 *Ralph W. Vandenberg*
Licensed Embalmer No. *4076*

P. O. Address *Spokane, Sp...*

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.