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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

C. W. Alexander

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35912
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4777

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 HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2206 E. 25th ST — Length of stay in 1b 75 yrs.

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 (If outside, give location) 2206 E. 25th ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Emma Middle: D. Last: Jackson

4. DATE OF DEATH Month Day Year: 10-13-57

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7-15-1862

9. AGE (In years last birthday) 95 — 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

11. BIRTHPLACE (City and state or country) Liberty, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Decoursey

14. MOTHER'S MAIDEN NAME Unknown

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. None

17. INFORMANT Address: JUNIOR MAXEY 2206 E 25th ST

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

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Interstitial Nephritis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senilizer Arteriosclerosis

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 446+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hematoma of forehead.

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 10-11-57, to 10-13-57 and last saw her/him alive on 10-13-57. 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) C. W. Alexander M.D.

22b. ADDRESS 1312 N [illegible]

22c. DATE SIGNED 10-15-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 10-16-57

23c. NAME OF CEMETERY OR CREMATORY HIGHLAND CEMETERY

23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.

24. FUNERAL DIRECTOR MANLOVE-WILLIAMS ADDRESS 1729 LYDIA

25. DATE RECD. BY LOCAL REG. 10-16-57

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

KP
2

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.....

Licensed Embalmer No. 399

P. O. Address 3712E 30

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.