

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35915

STATE FILE NUMBER

FILED OCT 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4549

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) <u>Kansas City</u> 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) <u>4807 E. 7th</u> HOSPITAL OR INSTITUTION <u>30 yrs.</u>				d. STREET ADDRESS (If outside, give location) <u>4807 E. 7th</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H</u> Last <u>James</u>				4. DATE OF DEATH <u>Sept-30-1957</u> Month <u>Sept</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>Feb-10-1881</u> Year <u>1881</u> Month <u>Feb</u> Day <u>10</u>	
9. AGE (In years) <u>76</u> last birthday Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			
11. BIRTHPLACE (City and state or country) <u>Buckner, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel James</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hughes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>495-03-3730A</u>		17. INFORMANT <u>Sam C. Campbell</u> Address <u>Strain Valley, Mo.</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>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>45 hrs</u> <u>5 yrs</u> <u>33 2 x</u>
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 <u>—</u> Month, Day, Year <u>—</u> a. m. <u>—</u> p. m. <u>—</u>							
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 <u>Dec., 1956</u> to <u>9-30-57</u> and last saw him alive on <u>9-29-57</u> Death occurred at <u>9:37</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Walter W. Cummins M.D.</u> (Degree or title)				22b. ADDRESS <u>1612 Prof Bldg</u>		22c. DATE SIGNED <u>9-30-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Oct 2-1957</u>		<u>Buckner Cem.</u>		<u>Buckner Mo.</u>	
24. FUNERAL DIRECTOR <u>C. H. Blackman & Son Inc. L.C.M.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>10-1-57</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)



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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..... *W. C. Quinn*

Licensed Embalmer No. *487*

P. O. Address..... *W. C. Quinn*

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.