

FILED NOV 5 1957

STANDARD CERTIFICATE OF DEATH

35997

STATE FILE NUMBER
4870

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

S. 300
1-57

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>Jackson</i>	
b. CITY OR TOWN <i>Kansas City</i> (outside corporate limits give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) <i>St. Bernard Hospital</i>		d. STREET ADDRESS <i>935 E. 4th St.</i>	
Length of stay in lb <i>40 yrs.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>Edna</i> Middle <i>May</i> Last <i>Mahan</i>			4. DATE OF DEATH Month <i>10</i> Day <i>18</i> Year <i>1957</i>			
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3 - 1905</i>	9. AGE (In years last birthday) <i>52</i>	F UNDER 1 YEAR Months <i>-</i> Days <i>-</i>	IF UNDER 24 HRS. Hours <i>-</i> Min. <i>-</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Invalid</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Invalid</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Thomas J. Mahan</i>	13b. MOTHER'S MAIDEN NAME <i>Anna M. Walter</i>	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT <i>Mr. John Pace</i>	Address <i>3428 Green K. E. Mo.</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured Skull Subdural Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>29000 21</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i>		
DUE TO (c)		
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 checked="" type="checkbox"/> (NO) <input type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.) <i>Fell down stairs</i>
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20c. TIME OF INJURY Hour <i>10:18</i> Month <i>10</i> Day <i>18</i> Year <i>57</i> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g.; in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. CITY, TOWN, OR LOCATION <i>Kansas City</i> COUNTY <i>Jackson</i> STATE <i>MO</i>
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21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Hugh H. Owens</i> (Degree or title) <i>Coroner</i>	22b. ADDRESS <i>1034 Park Bldg</i>	22c. DATE SIGNED <i>10-21-57</i>
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23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-22-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Louisburg Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Louisburg, Kansas</i>
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24. FUNERAL DIRECTOR <i>C. H. Blackman</i> ADDRESS <i>San Joe</i>	25. DATE RECD. BY LOCAL REG. <i>10-21-57</i>	26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i>
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H. C. Mo. (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 causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. OWENS

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. *4879*

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

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.