

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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36114  
STATE FILE NUMBER 4609

FILED OCT 24 1957

Registration District No. 393 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, North</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5225 N. Agnes</b>		Length of stay in lb <b>1 week</b>	d. STREET ADDRESS <b>929 S. Pope</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marion</b> Middle <b>Ivy</b> Last <b>Russell</b>			4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Jackson County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ben K. Hinde</b>		14. MOTHER'S MAIDEN NAME <b>Alice Faulconer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Wm. M. Russell, Indep., Mo.</b> 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) <b>Metastatic Carcinoma to lung.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Primary Carcinoma of Breast.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 Month</b> <b>15 Yrs</b> <b>170X</b>
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 <b>30 Sept 57</b> to <b>3 Oct 1957</b> and last saw her <sup>alive</sup> on <b>3 Oct 1957</b> . Death occurred at <b>1 A.M. 3 Oct 1957</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R. D. Dwyer</i> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>1806 First Ave. North Kan City, Mo</b>	22c. DATE SIGNED <b>7 Oct 1957</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>October 4, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brooking</b>	23d. LOCATION (City, town, or county) (State) <b>Raytown, Mo</b>
24. FUNERAL DIRECTOR <b>Ott &amp; Mitchell</b> <b>Indep., Mo.</b> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <b>10-4-57</b>	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

R. D. Dwyer



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.....

*Henry J. Mitchell*

Licensed Embalmer No. *398*

P. O. Address *Indep. M.*

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.