. Health,
& Welfare
. Public
h Service

S. 300
v. 1-56

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36145
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4662

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1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, Inside Limits Yes X No
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1805 E 12th St. Length of stay in Ib 3 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 X No
d. STREET ADDRESS (If outside, give location) 1015 PARK AVE Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First MARY Middle Last SMILY
4. DATE OF DEATH Month OCT. Day 4 Year 1957
5. SEX FEMALE
6. COLOR OR RACE NEGRO
7. MARRIED NEVER MARRIED WIDOWED DIVORCED X
8. DATE OF BIRTH June 7th 1918
9. AGE (In years last birthday) 39
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) DISHWASHER
10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT
11. BIRTHPLACE (City and state or country) KANSAS CITY, MO
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George Winstead
14. MOTHER'S MAIDEN NAME Matty Miller
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. 499 14 5230
17. INFORMANT CLARENCE WHITE Address 1015 Park Ave. K. C Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Congestion + Edema
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Insufficiency
DUE TO (c) Obesity
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 X NO

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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. M. Tillman M.D. Deputy Coroner
22b. ADDRESS 1618 Lydia Ave
22c. DATE SIGNED 10/5/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal
23b. DATE Oct 9 1957
23c. NAME OF CEMETERY OR CREMATORY Sweet Springs Mo.
23d. LOCATION (City, town, or county) (State) Sweet Springs Mo
24. FUNERAL DIRECTOR ADDRESS Adkins Funeral Home K. C. Mo.
25. DATE RECD. BY LOCAL REG. 10-8-57
26. REGISTRAR'S SIGNATURE Neva Minshall

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

L. M. Tillman

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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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 44

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.