

FILED NOV 14 1957

36183  
STATE FILE NUMBER  
5059

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5059

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</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>Research Hospital</b>		Length of stay in lb <b>1 Week</b>	d. STREET ADDRESS (If outside, give location) <b>641 1/2 Osage Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>A.</b> Last <b>Thurston</b>			4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17-1884</b>	9. AGE (In years last birthday) <b>73</b>	F UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired 1956 Employee</b>		10b. KIND OF BUSINESS OR <b>United Mfg. Co. Box-Maker</b>	11. BIRTHPLACE (City and state or country) <b>New Florence, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Don't Know</b>		13b. MOTHER'S MAIDEN NAME <b>Don't Know</b>		14. NAME OF HUSBAND OR WIFE <b>Gertrude Thurston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>510-05-9741</b>	17. INFORMANT Address (Son) <b>Richard Thurston, 326 So. 9th, K.C.K.</b>		
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>abdominal Carcinomatosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of pancreas (body + tail)</b>					<b>4 mo.</b>
DUE TO (c) _____					<b>157 +</b>
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"/>
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>1945</b> to <b>10-29-57</b> and last saw him alive on <b>10-29-57</b> Death occurred at <b>October 29 1957</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>L. F. Steffen M.D.</b> (Degree or title) MD			22b. ADDRESS <b>1103 Grand Ave K.C.Mo</b>		22c. DATE SIGNED <b>10/30/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct. 31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Jos. A. Butler's Sons, K.C.K.</b>		25. DATE RECD. BY LOCAL REG. <b>10-30-57</b>	26. REGISTRAR'S SIGNATURE <b>Alva Marshall</b>		

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  
MEDICAL CERTIFICATION  
L. F. Steffen



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 \_\_\_\_\_  
*Paul Bell*

Licensed Embalmer No. 3426 Miss  
P. O. Address Kansas City, Kansas

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.