

Health,
& Welfare
Public
Service

300
1-57

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.

Hugh H. Owens USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

FILED DEC 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40193
STATE FILE NUMBER
5512

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

| | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3516 Central | | Length of stay in lb Life | d. STREET ADDRESS 3516 Central | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ALICE G. BARKER | | | 4. DATE OF DEATH Month 11 Day 20 Year 57 | | | |
| 5. SEX Fe | 6. COLOR OR RACE Wh | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-9-1884 | | 9. AGE (In years less birthday) 73 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY XX | 11. BIRTHPLACE (City and state or country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME John Barker | | 13b. MOTHER'S MAIDEN NAME Margaret Riley | | 14. NAME OF HUSBAND OR WIFE XX | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, year or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Margaret Barker, 3516 Central, KC Mo | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH 4201 | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <i>History of Infection</i> | | | | | 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 Month, Day, Year a.m. p.m. | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her alive on _____ Death occurred at 6:10 P.M. _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 23a. SIGNATURE <i>Hugh H. Owens Coroner</i> | | | 23b. ADDRESS 1039 Pratt Blvd | | 22c. DATE SIGNED 11-22-57 | |
| 23c. BURIAL, CREMATION, RENOVATION (Specify) Burial | | 23d. DATE 11-23-57 | 23e. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's | | 23d. LOCATION (City, town, or county) (State) Kansas City Mo | |
| 24. FUNERAL DIRECTOR <i>Wagner Funeral Home, K6 Mo</i> | | 25. DATE RECD. BY LOCAL REG. 11-22-57 | | 26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i> | | |



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 *Thomas A. Gachler*

Licensed Embalmer No. *4995*
P. O. Address *K.C., Mo.*

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.