

FILED DEC 2 - 1957

STANDARD CERTIFICATE OF DEATH

40380
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5344

V. S. 300
Rev. 1-57

| | | | | | | | |
|--|-------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kansas City</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>307 N. Lawrence</u> | | | Length of stay in lb <u>50 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>307 N. Lawrence</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ANN</u> Last <u>SHENLEY</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July-8-1875</u> | | 9. AGE (In years) Months <u>82</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 11. BIRTHPLACE (City and state or country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Gray</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Ann Prim</u> | | 14. NAME OF HUSBAND OR WIFE <u>H. P. Shenley</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>—</u> | 17. INFORMANT <u>Miss Ollie May Thomas</u> | | | Address <u>H.P.M.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> 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 <u>2 1/2 hrs</u> <u>4201</u> |
| 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.) <u>—</u> | | | | |
| 20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year <u>—</u> p.m. <u>—</u> | | | 20d. INJURY OCCURRED WHILE AT <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.) <u>—</u> | | 20f. CITY, TOWN, OR LOCATION <u>Kansas City</u> | | | COUNTY <u>Jackson</u> | | STATE <u>Mo.</u> |
| 21. I attended the deceased from <u>Jan 56</u> , to <u>Nov. 12 1957</u> and last saw her alive on <u>Oct 15, 1957</u> Death occurred at <u>2:25 pm</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>D. L. Shereoran, M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>4606 St John Kemo</u> | | 22c. DATE SIGNED <u>11-13-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>11-14-1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>K.C. Kansas</u> | | |
| 24. FUNERAL DIRECTOR <u>C. J. Blackman & Son Inc.</u> ADDRESS <u>11. C. M.B.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>11-13-57</u> | | 26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u> | | |

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. K. L. SULLIVAN
 securing the medical certification in the specific manner required by V.S. 300, MO. REV. STAT. 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION



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., 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.