

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40446

STATE FILE NUMBER  
5173

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5173

S. 300  
av. 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>Oklahoma</b> b. COUNTY <b>Ottawa</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Miami</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>St. Joseph Hospital</b>		Length of stay in 1b <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>RR #2</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>STELLA</b> Middle <b>AGNES</b> Last <b>LA FALIER</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</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>Oct. 28, 1888</b>
9. AGE (In years last birthday) <b>69</b>		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) <b>Garment Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Garment Co.</b>	11. BIRTHPLACE (City and state or country) <b>Ottawa Co., Okla.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Joseph Skye</b>	13b. MOTHER'S MAIDEN NAME <b>Lucy Wadsworth</b>
14. NAME OF HUSBAND OR WIFE <b>Clarence</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>495-09-3719</b>
17. INFORMANT <b>Robert J. Satterfield - 6200 E. 86th St.</b>		Address <b>Kansas City, Mo.</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>Influenza, diffuse pneumonitis.</b> DUE TO (b) <b>Cirrhosis of liver</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary edema, cyanosis - tracheobronch</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>1 1/2 years</b> <b>480x</b>
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 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 <u>11-3-57</u> to <u>11-4-57</u> and last saw her alive on <u>11-4-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Vincent T. Williams M.D.</b>		22b. ADDRESS <b>836 Argyle Bldg</b>	
22c. DATE SIGNED <b>Nov 5</b>		23. NAME OF CEMETERY OR CREMATORY <b>G.A.R. Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-5-57</b>	
23c. LOCATION (City, town, or county) <b>Miami, Okla.</b>		(State)	
24. FUNERAL DIRECTOR <b>Melody McGilley-Eylar</b>		ADDRESS <b>Kansas City, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>11-5-57</b>		26. REGISTRAR'S SIGNATURE <b>new 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  
Vincent T. Williams

*Dr. Vincent T. Williams*

*9581*

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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 embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Melvin Bortose*

Licensed Embalmer No. *4903*

P. O. Address *KC 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.