

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 20 1957

40572

STATE FILE NUMBER

3101

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4417 Genesee		d. STREET ADDRESS (If outside, give location) 4417 Genesee	
3. NAME OF DECEASED (Type or print) First Middle Last Mr. James Patterson Rial		4. DATE OF DEATH Month Day Year Oct. 30, 1957	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Consultant - Forrester-Nace		10b. KIND OF BUSINESS OR INDUSTRY Box Co.	11. BIRTHPLACE (City and state or country) Lindenville, New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Simon S. Rial	
13b. MOTHER'S MAIDEN NAME Jane Eliza Patterson		14. NAME OF HUSBAND OR WIFE Ella M. Rial	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-03-6225	17. INFORMANT Address Mrs. Edna Bailey 4417 Genesee
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			331 X
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 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.) ITEM 1c CORRECTED	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		BY AFFIDAVIT OF Informant 6-24-59 JES	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 1953 to 10-30-1957 and last saw her/him alive on Aug 5, 1957 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. E. Carlson M.D.		22b. ADDRESS 1314 Prof. Bldg.	
22c. DATE SIGNED 1 Nov 1957			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 2, 1957	
23c. NAME OF CEMETERY OR CREMATORY Mt. Washington		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 11-1-57	
ADDRESS Kansas City, Mo		26. REGISTRAR'S SIGNATURE Neva Minshall	



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 *William M. Turner*

Licensed Embalmer No. *4648*

P. O. Address *Lamas City*

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.