

Dept. Health,
 & Welfare
 S. Public
 Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40525
 STATE FILE NUMBER
 3409

FILED DEC 5 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3409

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Woodland Nursing Home</i>		Length of stay in 1b <i>11 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>142 N. Brighton</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clarence Earl Rising</i>			4. DATE OF DEATH Month Day Year <i>Nov-14-1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March-5-1896</i>	9. AGE (In years last birthday) <i>61</i>	IF UNDER 1 YEAR Months Days Hours Min. <i>- - - -</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Solo</i>	11. BIRTHPLACE (City and state or country) <i>St. Joseph, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Clarence E. Rising</i>		13b. MOTHER'S MAIDEN NAME <i>Matilda J. Johnson</i>		14. NAME OF HUSBAND OR WIFE <i>Katherine Rising</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes or no or unknown) (If yes, give year or dates of service) <i>Yes U.W. # 1</i>		16. SOCIAL SECURITY NO. <i>497-36-8447</i>	17. INFORMANT Address <i>142 N. Brighton</i> <i>Mrs. Katherine Rising</i>		
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>Cerebral Vascular Accident</i> DUE TO (b) <i>Generalized Atherosclerosis</i> DUE TO (c) <i>Chronic Pyelitis</i> 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)					INTERVAL BETWEEN ONSET AND DEATH <i>few months</i> <i>331 X</i>
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 <i>6-8-55</i> to <i>11-14-57</i> and last saw him alive on <i>10-1-57</i> Death occurred at <i>1207 PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert S. Haid, M.D.</i> (Degree & title)		22b. ADDRESS <i>4126 St. John</i>		22c. DATE SIGNED <i>11-15-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>10-16-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Maysville, Mo.</i>	
24. FUNERAL DIRECTOR <i>C. J. Blackman, Inc.</i> <i>11. P. Mo.</i>		ADDRESS	25. DATE RECD. BY LOCAL REG. <i>11-15-57</i>	26. REGISTRAR'S SIGNATURE <i>Neve Minshall</i>	

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. Recording the medical certification in the same manner required by 1937 Act, MO. 1937.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 Robert L. Ward

(Licensed Embalmer's Statement on Reverse Side)

Rest. Board
1 P.M.



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 *Bert B. Bennett*

Licensed Embalmer No. *4656*

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.