

FILED NOV 20 1957

STANDARD CERTIFICATE OF DEATH

THE DIVISION OF HEALTH OF MISSOURI

40586
STATE FILE NUMBER
5124

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 type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4909 Proastwood			Length of stay in lb 20 Yrs		d. STREET ADDRESS (If outside, give location) 4909 Proastwood Rd		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CARL Walker SANFORD				4. DATE OF DEATH Month Day Year Nov 1 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5 1886		9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. 71 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINE TYPE OPER			10b. KIND OF BUSINESS OR INDUSTRY K.P. STAR		11. BIRTHPLACE (City and state or country) Mexico Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME James P Sanford			13b. MOTHER'S MAIDEN NAME Annabelle M'Gee		14. NAME OF HUSBAND OR WIFE Eula Sanford		
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. 417-07-3849		17. INFORMANT Address Mrs Eula Sanford KANSAS CITY, MO.			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Hemorrhage. DUE TO (c) Essential Hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 3 days Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). 331+						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 1953 to 1 Nov - 57 and last saw him alive on 1 Nov - 57 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) Robert M. Myers M.D.				22b. ADDRESS 2225 Dualla Bldge		22c. DATE SIGNED 2 Nov 57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-2-57	23c. NAME OF CEMETERY OR CREMATORY Edmwood Cemetery		23d. LOCATION (City, town, or county) Mexico Missouri		(State)
24. FUNERAL DIRECTOR Sheil Funeral Home & Co.				25. DATE RECD. BY LOCAL REG. 11-2-57		26. REGISTRAR'S SIGNATURE Neva Marshall	

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

Robert M. Myers

*Dr. Robert M. Myers
Secretary Eastern Mo.*



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. Phil*

Licensed Embalmer No. *4954*

P. O. Address *N.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.