

338  
 Health,  
 & Welfare  
 S. Public  
 Health Service

S. 300  
 v. 1-56

Security - The medical certificate in this form is specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 L.S. Daigle

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED DEC 11 1957

40638  
 STATE FILE NUMBER  
 5508  
 Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

|  |                        |   |   |   |  |
|--|------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson   |                        |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. CITY/TOWN Jackson |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Kansas City   |                        | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Kansas City   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Forest Rest Home   |                        | Length of stay in lb 30 Yrs   | d. STREET ADDRESS 2316 Michigan   |   | (If outside, give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Anna Middle B Last Thurman  |                        |   | 4. DATE OF DEATH<br>Month 11 Day 17 Year 57   |   |  |
| 5. SEX Female 3  | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 21 1897 60  | 9. AGE (In years last birthday)<br>IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife  |                        | 10b. KIND OF BUSINESS OR INDUSTRY At Home   | 11. BIRTHPLACE (City and state or country) Colbert, Okla. 1   |   | 12. CITIZEN OF WHAT COUNTRY? USA   |
| 13. FATHER'S NAME Peter Hall   |                        |   | 14. MOTHER'S MAIDEN NAME Unknown  |   |  |
| 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. None  | 17. INFORMANT Address Mary Moore 216 Froupe K.C. K.   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardio-vascular Disease<br>DUE TO (c) |                        |   |   |   | INTERVAL BETWEEN ONSET AND DEATH 443+  |
| 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.)  |   |   |  |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year  |                        |   |   |   |  |
| 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 July 1957, to 11/17/57 and last saw her alive on 11/17/57. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.   |                        |   |   |   |  |
| 22a. SIGNATURE (Day or title) L.S. Daigle, M.D.  |                        |   | 22b. ADDRESS 212 2 Truman Bldg  |   | 22c. DATE SIGNED 11/18/57  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 23b. DATE 11-23-57  | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery   |   | 23d. LOCATION (City, town or county) (State) Kansas City, Mo   |
| 24. FUNERAL DIRECTOR name-love- Williams 1729 Lydia  |                        | 25. DATE RECD. BY LOCAL REG. 11-21-57   |   | 26. REGISTRAR'S SIGNATURE neva Marshall   |  |



18, 191

191

STATEMENT BY LICENSED EMBALMER

of the State of

County of

City of

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 *J. J. Manlove*

Licensed Embalmer No. 3994

P. O. Address 3712 E 38

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.