

Dept. Health,
r. & Welfare
S. Public
alth Service

S. 300
ev. 1-56

Securing the medical certification in the 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
John A. Griffith, Jr.

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44385
STATE FILE NUMBER
5672
Registrar's No.

Registration District No. 149 Primary Registration District No. 002

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>KANSAS.</i> b. COUNTY <i>Sabelle</i>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City, Mo.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Parsons</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Lukes Hosp.</i>			Length of stay in 1b <i>10/29-57 to 11/30</i>		d. STREET ADDRESS (If outside, give location) <i>1500 Belmont</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>Blanch</i> Middle <i>MAE</i> Last <i>Haiseher</i>				4. DATE OF DEATH Month <i>Nov.</i> Day <i>30</i> Year <i>1957</i>									
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 1, 1884</i>		9. AGE (In years last birthday) <i>73</i>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Sam Gleason</i>						14. MOTHER'S MAIDEN NAME <i>Carolyn Cain</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital records</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>Hypostatic Bronchial pneumonia</i>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>gastric resection</i>										5410			
DUE TO (c) <i>duodenal ulcer</i>													
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 <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>													
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 <i>10-29-57</i> to <i>11-30-57</i> and last saw ^{her} _{him} alive on <i>11-30-57</i> Death occurred at <i>8:15 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>John A. Griffith Jr. M.D.</i>						22b. ADDRESS <i>6500 Granada Dr.</i>			22c. DATE SIGNED <i>11-30-57</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>11-30-57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hope cem.</i>				23d. LOCATION (City, town, or county) (State) <i>Corning, New York</i>					
24. FUNERAL DIRECTOR <i>Walter General Home</i>				ADDRESS <i>K.C. Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>11-30-57</i>		26. REGISTRAR'S SIGNATURE <i>neva minshall</i>					

DEC 18 1957

1-3150



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.. *Murray Wilson*
Licensed Embalmer No. *498*

P. O. Address *Shannon*

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.