

Dept. Health,
c. & Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47440-1
STATE FILE NUMBER
6146

FILED JAN 17 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6146

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3014 East 12th</u>		Length of stay in lb <u>14 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>3014 East 12th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle _____ Last <u>White</u>			4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1957</u>
5. SEX <u>Male</u> <input type="checkbox"/> <input checked="" type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 1882</u>
9. AGE (In years at birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lock Smith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geo White Key</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Edna Maude White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>513 01 8303</u>	17. INFORMANT <u>Jimmy Neal White</u> Address <u>3501 1/2 East 9th Mo. K.C.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Doublel Hemorrhage</u> DUE TO (c) <u>from chronic ulcer</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5410</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days before death</u>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" 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 <u>Aug</u> to <u>1956</u> and last saw her/him alive on <u>Dec 23, 1957</u> Death occurred at <u>Dec 23, 1957</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James J. Ferguson</u> (Degree or title)		22b. ADDRESS <u>410 Bryant Bld</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Dec. 26, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maples Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas, City, Kansas</u>
24. FUNERAL DIRECTOR <u>Gates Funeral Home Kan City Kan</u>		25. DATE RECD. BY LOCAL REG. <u>12-26-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>

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. James T. Ferguson, Missouri State Health Commissioner, Springfield, Missouri

27

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 *Paul B. Williamson*

Licensed Embalmer No. *5009*

P. O. Address *Overland Park*

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.