

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1184

STATE FILE NUMBER

175

FILED FEB 3 1958

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 175

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		d. STREET ADDRESS 1611 Virginia	
3. NAME OF DECEASED (Type or print) First Middle Last Mamie Carter		4. DATE OF DEATH Month Day Year January 5, 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> & DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Colorado
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Willie Carter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Gracie McLaughlin, daughter-in-law
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis with malnutrition and dehydration. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 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 45 hr
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 <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>1-4-58</u> to <u>1-5-58</u> and last saw her alive on <u>1-5-58</u> Death occurred at <u>3:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. R. Peterson M.D.</i> (Degree or title)		22b. ADDRESS 600 East 22nd Street	
22c. DATE SIGNED 1-9-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 1/13/58		23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	
23d. LOCATION (City, town, or county) Kansas City		STATE Mo	
24. FUNERAL DIRECTOR Manlove & Williams		ADDRESS I729 Lydia	
25. DATE RECD. BY LOCAL REG. 1-13-58		26. REGISTRAR'S SIGNATURE <i>neva minshall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *L. J. Manlove*

Licensed Embalmer No. *3994*
P. O. Address *3112 E. 30th*

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.