

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1212

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 51

300
-57

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) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Westport Nursing Home		Length of stay in 1b 37 Yrs.	d. STREET ADDRESS (If outside, give location) 2818 East 11th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle POISSANT Last DE CLOUD			4. DATE OF DEATH Month Jan. Day 4, Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1860		9. AGE (In years last birthday) 98 7/8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Unionville, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME George Lute		13b. MOTHER'S MAIDEN NAME Louisa Maxley		14. NAME OF HUSBAND OR WIFE James F. De Cloud	
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 Mrs. Earl Deputy 310 West 49th	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchus Pneumonia (Terminal)					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Myocardial Insufficiency					6 mo.
DUE TO (c)					4 1/2 - 2-F
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) united fracture of hip					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 Kansas City Jackson MO	
21. I attended the deceased from October 10, 57 to Jan. 4, 1958 and last saw her alive on Jan 4th, 1958 Death occurred at 5:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Joseph Getelson M.D.			22b. ADDRESS 900 Rialto Bldg		22c. DATE SIGNED 1-5-58
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-6-58		23c. NAME OF CEMETERY OR CREMATORY Shawnee Cemetery	
			23d. LOCATION (City, town, or county) Shawnee, Kansas		(State)
24. FUNERAL DIRECTOR Freeman Mortuary			ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 1-5-58
26. REGISTRAR'S SIGNATURE Neva Marshall					

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Joseph Getelson

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 *John E. Freeman*

Licensed Embalmer No. 481
P. O. Address 104 Or. 42nd

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.