

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005407
STATE FILE NUMBER 657

FILED MAR 3 - 1958

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

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		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 390 W. MCGEE STREET WESTPORT NURSING HOME		Length of stay in lb 40 yrs	d. STREET ADDRESS (If outside, give location) 3828 Belle Fontaine Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last CARTER			4. DATE OF DEATH Month Feb. Day 6 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 MAY 29, 1874	9. AGE (In years last birthday) 83 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) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) WOODLAND, PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JAMES DORAN		13b. MOTHER'S MAIDEN NAME ELIZABETH MEAD		14. NAME OF HUSBAND OR WIFE FRANK E. CARTER	
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 ESTIL D. CARTER Address 1438 E. 76th ST. KANSAS CITY, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneuronia			INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Virus Infection		
	DUE TO (c) Contributing cause is Mitral lesion		
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 <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 _____	
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21. I attended the deceased from **1-25-58** to **2-6-58** and last saw her alive on **2-3-58**
Death occurred at **5:25 P.** m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James W. Graham M.D.		22b. ADDRESS 518 Arroyo Blvd.	22c. DATE SIGNED 2-7-58
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23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE FEB 9 1958	23c. NAME OF CEMETERY OR CREMATORY MACHELAH CEMETERY	23d. LOCATION (City, town, or county) (State) LEXINGTON MISSOURI
24. FUNERAL DIRECTOR D.W. Newcomers Sons, KANSAS CITY, MO		25. DATE RECD. BY LOCAL REG. 2-8-58	26. REGISTRAR'S SIGNATURE neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. James W. Graham USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Apr 1-5-676

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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 *Bern Lawler*

Licensed Embalmer No. *4915*

P. O. Address *478 32nd Keo*

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.