

Health,
Welfare
Public
Service

58-005416

STATE FILE NUMBER

FILED MAR 10 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 842

300
1-57

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) 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 type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.E. OSTEOPATHIC</u>		Length of stay in lb <u>80 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>4009 MORRELL</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ISABELLE</u> Middle <u>--</u> Last <u>CHERRY</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>15,</u> Year <u>1958</u>		
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5. SEX <u>FEMALE</u>	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>JUNE 2, 1873</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	IF UNDER 24 HRS. Hours <u>--</u> Min. <u>--</u>
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10a. USUAL OCCUPATION (Give kind of work done during last year or if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>CLEVELAND, OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>P.A. LOFTUS</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA O'BRIAN</u>	14. NAME OF HUSBAND OR WIFE <u>F.H. CHERRY</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>*****</u>	17. INFORMANT <u>MRS. R. T. JARRETT</u> Address <u>K.C. MO.</u>
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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>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Intestinal Obstruction</u>	5 days
	DUE TO (c) <u>Unknown</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ventricular strain</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour <u>--</u> a.m. <u>--</u> p.m. <u>--</u>	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
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21. I attended the deceased from <u>7-31-53</u> to <u>2-15-58</u> and last saw her <u>alive</u> on <u>2-15-58</u> Death occurred at <u>5:42</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Glenn W. Springer, D.O.</u>	22b. ADDRESS <u>5902 St. John Ave. Kansas City, Mo.</u>	22c. DATE SIGNED <u>2-17-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB. 18, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY, MISSOURI</u>	(State)
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24. FUNERAL DIRECTOR'S ADDRESS <u>C.P. Blackman Son Inc. N.P. 170</u>	25. DATE RECD. BY LOCAL REG. <u>2-17-58</u>	26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms with or without. 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 *W.C. Bism*

Licensed Embalmer No. *4879*

P. O. Address *W.C. Mo.*

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.