

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005660
STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 678

300
-57

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>St. Marys Hosp.</u>		Length of stay in lb <u>71 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>4351 Bell</u>
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Ivy</u> Last <u>Kress</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16-1886</u>
9. AGE (In years at birthday) <u>71</u>		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during last 6 months if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Monroe Larson</u>	13b. MOTHER'S MAIDEN NAME <u>Augusta L. Burke</u>
14. NAME OF HUSBAND OR WIFE <u>Joseph Kress</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>486 01 0457B</u>
17. INFORMANT <u>Joseph Kress</u>		Address <u>4351 Bell K C Mo</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>Pneumo pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis</u>			<u>12 days</u>
DUE TO (c) <u>Arterio sclerotic Heart Dis</u>			<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thrombotic occlusion right popliteal artery</u>			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.) <u>420?</u>		
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	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>1-31-58</u> to <u>2-8-58</u> and last saw her alive on <u>2-7-58</u> Death occurred at <u>8:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In degree or title) <u>Hubert M Parker MD</u>		22b. ADDRESS <u>928 Arroyo Bldg</u>	22c. DATE SIGNED <u>2-9-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 10-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park,</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR <u>Gates Funeral Home</u>		ADDRESS <u>Kan City, Kan</u>	25. DATE RECD. BY LOCAL REG. <u>2-9-58</u>
26. REGISTRAR'S SIGNATURE <u>neva Minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Hubert M. Parker
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 *Paul R. Williamson*

Licensed Embalmer No. *5009*
P. O. Address *Overland Park, 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.