

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009854
STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1304

300
1-57

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) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys Hospital		d. STREET ADDRESS (If outside, give location) 908 East 42 St	
3. NAME OF DECEASED (Type or print) First Mabel Middle Rose Last Clark		4. DATE OF DEATH Month Mar. Day 11 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 Feb. 18 1880
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) Adrain Kansas.
13a. FATHER'S NAME William Harmon Brown		13b. MOTHER'S MAIDEN NAME Selena Trezise	14. NAME OF HUSBAND OR WIFE John Clark.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wtg or dates of service) no		16. SOCIAL SECURITY NO. 497-40-3502	17. INFORMANT Address Mrs Jean Parker 3700 E. 48 St. North K.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			3/11/58
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20e. CITY, TOWN, OR LOCATION _____		20f. COUNTY STATE	
21. I attended the deceased from 3/10/58 to 3/11/58 and last saw her alive on 3/11/58 Death occurred at 10:25 Am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. L. Forster M.D.		22b. ADDRESS 1010 Perry Bldg #8 Wm	22c. DATE SIGNED 3/12/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar. 13 1958	23c. NAME OF CEMETERY OR CREMATORY Fairview	23d. LOCATION (City, town, or county) (State) Near Wamego, Kansas
24. FUNERAL DIRECTOR Mrs C.L. Forster Funeral Home Inc.		25. DATE RECD. BY LOCAL REG. 3-12-58	26. REGISTRAR'S SIGNATURE neva minshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

C. G. Lelitch



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 *J. Deigil Heresch*.....

Licensed Embalmer No. *3599*.....

P. O. Address *J. C. No.*.....

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.