

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010097  
STATE FILE NUMBER  
1191

FILED MAR 31 1958

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

300  
-57 0

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 General #2		d. STREET ADDRESS (If outside, give location) 926 Olive HIGHLAND	
3. NAME OF DECEASED (Type or print) Winnie		4. DATE OF DEATH March 2, 1958	
5. SEX Female 3		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH - app. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Galena, Kans.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE unknown		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 Monroe Williams, K.C. 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) Bronchopneumonia. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 42 1/2
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 Month, Day, Year a.m. p.m.		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	
21. I attended the deceased from 2-28-58, to 3-2-58 and last saw her alive on 3-2-58 Death occurred at 7:20 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. P. Peterson MD		22b. ADDRESS 600 E. 22nd Street	
22c. DATE SIGNED 3-4-58		23a. BURIAL, CREMATION, REMOVE (Specify) Anatomical 3-21-58	
23b. DATE 3-21-58		23c. NAME OF CEMETERY OR CREMATORY K.C. College of Podiatry, Kansas City, Mo.	
23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS 1729 Tyler	
24. DATE RECD. BY LOCAL REG. 3-5-58		24. REGISTRAR'S SIGNATURE never minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.  
W. R. Peters ON

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 *D. J. M... Jr.* .....

Licensed Embalmer No. *3994* .....  
P. O. Address *3712 E 30th* .....

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.