

FILED MAR 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010300

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 132

300

-57

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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 Independence		c. CITY OR TOWN Independence, Missouri	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Eberting N.H. Indep.		d. STREET ADDRESS (If outside, give location) 11101 E. 20th	
3. NAME OF DECEASED (Type or print) First Middle Last MELESSIA JANE DOUDNEY		4. DATE OF DEATH Month March Day 12 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 5-6-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Stanton, Iowa
13a. FATHER'S NAME Ilan Fay Carlisle		13b. MOTHER'S MAIDEN NAME Anne Unknown	14. NAME OF HUSBAND OR WIFE Joseph E
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr. Fay Doudney 11101 E. 20th. Indep. 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) Respiratory congestion			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arteriosclerosis - myocardial			3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left cerebral thrombosis			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 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 12-14-57 to 3-10-58 and last saw her ^{her} _{him} alive on 3-11-58 Death occurred at 7:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) E. H. Hensch MD		22b. ADDRESS 10901 WINDYBROOK	22c. DATE SIGNED 3/12/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-14-1958	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or country) (State) Kansas City 33 Missouri
24. FUNERAL DIRECTOR ADDRESS FLORAL HILLS MEM. CHAPELS, INC K.C. MO		25. DATE RECD. BY LOCAL REG. 3-14-58	26. REGISTRAR'S SIGNATURE [Signature]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

