

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014088
STATE FILE NUMBER

FILED MAY 2 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1850

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeside Hosp.			Length of stay in 1b 43 yrs.		d. STREET ADDRESS (If outside, give location) 8115 Lydia		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle C. Last Breshears				4. DATE OF DEATH Month April Day 10 Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1914		9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME James Colton			13b. MOTHER'S MAIDEN NAME Agnes Owens			14. NAME OF HUSBAND OR WIFE Odie Breshears		
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 Odie Breshears Address 8115 Lydia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism							INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Abdominal Surgery.							3 1/2 hrs.	
DUE TO (c) Cholecystitis							584X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cholecystitis & Cholelithiasis							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.) 7					
20c. TIME OF INJURY Hour 2:15 PM Month, Day, Year			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>Jan. 19, 48</u> and last saw her/him alive on <u>4-10-58</u> Death occurred at <u>2:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Wm. W. Thompson D.O.				22b. ADDRESS 6218 Cooper St. #14		22c. DATE SIGNED 4-11-58		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/12/58	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City, town, or country) (State) Kansas City, Missouri			
24. FUNERAL DIRECTOR ADDRESS Earp & Sons 4707 Truman Rd.				25. DATE RECD. BY LOCAL REG. 4-11-58		26. REGISTRAR'S SIGNATURE Neva Minshall		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Wm. W. Thompson



Anderson

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

William H. Earp

Licensed Embalmer No. *4728*

P. O. Address *W.C. 210*

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.