

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014617  
STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. 50 Primary Registration District No. 5572 Registrar's No. 96

300  
1-57  
0003

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Unknown</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWNSHIP <u>Rural Prairie</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Unknown</u> Inside Limits <u>Unknown</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson Co Hosp</u> Length of stay in 1b <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm <u>Unknown</u>	

3. NAME OF DECEASED (Type or print) First <u>STEVE</u> Middle <u>-----</u> Last <u>Juras</u>			4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years) 1st birthday) Months <u>Unknown</u> Days <u>Unknown</u>	IF UNDER 1 YEAR Hours <u>Unknown</u> Min. <u>Unknown</u>	IF UNDER 24 HRS. Hours <u>Unknown</u> Min. <u>Unknown</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (City and state or country) <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Independence, Missouri</u> <u>Jackson County Hospital Records</u>
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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>PULMONARY EDEMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>ARTERIO SCLEROTIC Heart disease</u>		
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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 _____
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21. I attended the deceased from <u>4-29-58</u> to <u>5-1-58</u> and last saw him alive on <u>5-1-58</u> Death occurred at <u>7:30 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Shelby Workman M.D.</u>	22b. ADDRESS <u>G. Co. Hospital</u>	22c. DATE SIGNED <u>5/2/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u>	23b. DATE <u>May 2, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>University of Kansas City, Kansas City, Missouri</u>	23d. LOCATION (City, town, or county) (State) _____
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24. FUNERAL DIRECTOR <u>Langsford's</u> ADDRESS <u>uneral Home Lee's Summit, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>5-2-1958</u>	26. REGISTRAR'S SIGNATURE <u>N.B. Langsford</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 13 1958

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 DIVISION OF PUBLIC HEALTH  
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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 *H. B. Longford* .....  
 Licensed Embalmer No. *382*  
 P. O. Address *Lees Summit*

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.

MISSISSIPPI DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 DIVISION OF PUBLIC HEALTH  
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