

Dr. Health,
& Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018284
STATE FILE NUMBER

FILED MAY 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2125

S. 300
v. 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 Gen'l Hosp. #1		d. STREET ADDRESS (If outside, give location) 721 E. 8 St.	
3. NAME OF DECEASED (Type or print) First Michael Middle Obadiah Last James		4. DATE OF DEATH Month 4 Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUND COLLECTOR		10b. KIND OF BUSINESS OR INDUSTRY Vol. of AMERICA	11. BIRTHPLACE (City and state or country) LONO, ARKANSAS
13a. FATHER'S NAME William James		13b. MOTHER'S MAIDEN NAME FLORENCE McANN	14. NAME OF HUSBAND OR WIFE BESSIE JAMES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or years of service) YES W.W.II		16. SOCIAL SECURITY NO. 240-03-7607	17. INFORMANT BESSIE JAMES 2531 HARMONY DR. 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) Delerium tremens			INTERVAL BETWEEN ONSET AND DEATH 307+
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			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 <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 April 18, 1958 to April 18, 1958 and last saw him alive on April 18, 1958 Death occurred at 3:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. B. Brown, M.D.		22b. ADDRESS 24th & Cherry	22c. DATE SIGNED 4-20-58
23a. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>	23b. DATE 5-5-58	23c. NAME OF CEMETERY OR CREMATOR Western Jewish College	23d. LOCATION (City, town, county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR Wester's: 2332 Main St. P. O. Box 110		25. DATE RECD. BY LOCAL REG. 4-26-58	26. REGISTRAR'S SIGNATURE neva minshall

B. I. BIRTHS USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



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.....

Licensed Embalmer No. 4675

P. O. Address... X. C. S. Mo

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.