

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018502

STATE FILE NUMBER

2384

FILED MAY 29 1958

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

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran		Length of stay in 1b 45 years	
3. NAME OF DECEASED (Type or print) First John Middle Muir Last Sills		4. DATE OF DEATH Month May Day 8 Year 1958	
5. SEX Male	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 Jan. 28, 18'81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
13a. FATHER'S NAME Albert M. Sills		13b. MOTHER'S MAIDEN NAME Fannie Muir	11. BIRTHPLACE (City and state or country) Kansas City, Missouri
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. 486-01-9408	12. CITIZEN OF WHAT COUNTRY? USA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of basilar artery		14. NAME OF HUSBAND OR WIFE Teresa B. Sills	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
DUE TO (c) hypertension		32-2-8.00 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension heart disease loss of heart function		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. _____		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 October 22, 1957 to May 8, 1958 and last saw her/him alive on May 8, 1958 Death occurred at 10:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) G. Comer Bates, M.D.	
22b. ADDRESS 329 Armour Road North Kansas City, Mo.		22c. DATE SIGNED May 9, 1958	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 10, 1958	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR ADDRESS Stine & McClure Und. Co., K. C., Mo.		25. DATE RECD. BY LOCAL REG. 5-10-58	26. REGISTRAR'S SIGNATURE Neva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

G. Comer Bates

10-5:30

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 *Eugene L. [Signature]*

Licensed Embalmer No. *4633*
P. O. Address *A. C. [Signature]*

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.