

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018543

STATE FILE NUMBER

2308

MAY 23 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 Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Walnut Nursing Home		Length of stay in 1b 55 Yrs.	d. STREET ADDRESS (If outside, give location) 3522 Walnut Street
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) GEORGE DAVID STORRS			4. DATE OF DEATH May 5th, 1958		
First	Middle	Last	Date	Month	Day Year

5. SEX Male	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 May 31st, 1876	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) LaGrange, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Storrs	13b. MOTHER'S MAIDEN NAME Wilhelmina Rhoda	14. NAME OF HUSBAND OR WIFE Rosa Burke Storrs
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 486-09-9615A	17. INFORMANT George B. Storrs, 2736 Raytown Rd., K.C. 28, Mo.
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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) Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Encephalo malacia.	5 yrs.
	DUE TO (c) Arteriosclerosis - Generalized.	10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) General Inanition and Senility.		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 Month, Day, Year a.m. p.m.	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 April 1958 , to 5 May 1958 and last saw him alive on 5 May 1958 . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wallace H. Graham, M.D. (Degree or title)	22b. ADDRESS 518 Argyle Bldg.	22c. DATE SIGNED 6 May '58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 8, 1958	23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery	23d. LOCATION (City, town, or county) (State) Quincy, Illinois
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24. FUNERAL DIRECTOR FREEMAN MORTUARY, Kansas City, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 5-6-58	26. REGISTRAR'S SIGNATURE Wm Marshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Wallace H. Graham

MEDICAL CERTIFICATION

HA. 1-0111
Before noon

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 *Clyde K Barnes*

Licensed Embalmer No. *4793*
P. O. Address *K. C. 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.