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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018570

STATE FILE NUMBER

FILED MAY 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2213

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 Grain Valley 7009
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in 1b 2 MO	d. STREET ADDRESS (If outside, give location) Edwardsville Sta.
3. NAME OF DECEASED (Type or print) BRIDIE TOTTON			4. DATE OF DEATH Month Day Year 4 29 58
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 5/1/1915
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, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Wm P. AHERN	
13b. MOTHER'S MAIDEN NAME KATHLEEN BENSON		14. NAME OF HUSBAND OR WIFE Wayne A. TOTTON	
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 Wayne A. TOTTON, Grain Valley, 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) Multiple myeloma			INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			203X
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.)	
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	
21. I attended the deceased from 10-15-57 to <del>2-24-58</del> 4-29-58 and last saw her alive on 4-28-58 Death occurred at 8:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wilson H. Miller, M.D.		22b. ADDRESS 4620 Indep. Ave Kansas City Mo	
22c. DATE SIGNED 4-29-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/1/58	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR Colonial Skail Funeral Home		ADDRESS S. C. Mo.	25. DATE RECD. BY LOCAL REG. 4-30-58
		26. REGISTRAR'S SIGNATURE neva Minshall.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Wilson H. Miller  
All diseases in Part I must be causally related.

4620 Sunday, June.

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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 Richard P. Canoe

Licensed Embalmer No. 4829

P. O. Address KC 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.