

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018669

STATE FILE NUMBER

FILED JUN 5 1958

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 112

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural - Brairie</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Kansas City 3008</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson Co. Hospital 5 yrs</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>Unknown</b>
		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>William</b> Last <b>Eastern</b>		DATE OF DEATH Month <b>5</b> Day <b>16</b> Year <b>58</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1878</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Terrington, Conn. 1</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Divorced Independence, Mo.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, by appointment; if yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Jackson County Hospital Records</b>
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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) <b>Pulmonary Edema</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>Anterior Salivary Gland Infection</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		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.	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
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21. I attended the deceased from _____ to _____ and last saw her alive on <b>5-16-1958</b> Death occurred at <b>6:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Karol Watson, MD</b> (Degree or title)	22b. ADDRESS <b>Jackson Co. Hospital</b>	22c. DATE SIGNED <b>5-17-1958</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Anatomical</b>	23b. DATE <b>May 19, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>University of Kansas City, Kansas City, Mo.</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>Langsford Funeral Home</b> <b>Lee's Summit, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>May 16-1958</b>	26. REGISTRAR'S SIGNATURE <b>D. B. Langsford</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

JUN 3 1958

STATEMENT BY LICENSED EMBALMER

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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 *D. B. Langford Jr.*

Licensed Embalmer No. *4962*

P. O. Address *Lee's 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.