

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022200

STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 145

|   |  |  |                                     |
|---|--|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b> |                                     |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Rural Prairie</b>           |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>Kansas City</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL INSTITUTION <b>JACKSON Cottages</b> |  | Length of stay in lb <b>10 mo.</b>   | d. STREET ADDRESS <b>2918 TRACY</b> |

|   |                               |  |  |  |   |
|---|-------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>IDA</b> Middle <b>MAE</b> Last <b>HALEY</b>                               |                               |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1958</b>  |  |   |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 8 - 1978</b>                            |  | 9. AGE (In years last birthday) <b>80</b>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Practicle Nurse</b>     |                               | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>John Haley</b>  |                               |  | 14. MOTHER'S MAIDEN NAME<br><b>Bill Dillon</b>                       |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |                               | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT Address<br><b>Mrs. Hartfelt - 7043 Chestnut</b>        |  |   |

|   |   |   |
|---|---|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL Thrombosis</b> |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>ARTERIO Sclerosis</b> <b>332X</b> |   |
| -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?<br>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<br>Hour <b>2:20</b> Month, Day, Year  |  |   |
| 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 <b>8-14-57</b> to <b>7-2-58</b> and last saw her <b>alive</b> on <b>7-2-58</b><br>Death occurred at <b>2:20</b> p. m on the date stated above; and to the best of my knowledge, from the causes stated. |   |                                   |
| 22a. SIGNATURE<br><b>David W. ...</b>  | 22b. ADDRESS<br><b>Jackson Co. Hospital</b> | 22c. DATE SIGNED<br><b>7-3-58</b> |

|  |                            |   |  |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>7-5-58</b> | 23c. NAME OF CEMETERY OR CREMATOR<br><b>St. Mary's Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Mo.</b> |
| 24. FUNERAL DIRECTOR<br><b>Melody-McBally-Taylor</b>       |                            | ADDRESS<br><b>1800 ...</b>                                      | DATE RECD. BY LOCAL REG.<br><b>5-1958</b>                                |
| 26. REGISTRAR'S SIGNATURE<br><b>N. B. Langford</b>         |                            |   |  |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

4830

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 *Malvin Barton*

Licensed Embalmer No. *490*

P. O. Address *KCA*

Note: The above MUST BE SIGNED BY ..... IN HIS OWN HANDWRITING. (P)  
to comply with the above constitutes grounds for .....  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, facts should be so stated above.