

t. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029043  
STATE FILE NUMBER  
3822

FILED AUG 27 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
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) HOSPITAL OR INSTITUTION <b>BRESTWOODS HOSPITAL 2700 TRACY</b>		Length of stay in 1b <b>40 YEARS</b>	
d. STREET ADDRESS <b>4324 MERCIER</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSE MARY CAMERON</b>			4. DATE OF DEATH Month Day Year <b>August-7, 1958</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 7, 1875</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER - AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (City and state or country) <b>SANDUSKY, OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>UNKNOWN JOHANNES</b>	
13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>FRANK ROSS CAMERON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>W.A. CAMERON - KANSAS CITY, MO</b>		Address <b>4324 MERCIER</b>	
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>Cardiac Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral embolus with thrombosis</b>			<b>3 days</b>
DUE TO (c) <b>Cerebral and Generalized Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Atherosclerosis</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.)	
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 <b>June 38</b> , to <b>June 7 1958</b> and last saw her alive on <b>8-7-58</b> Death occurred at <b>5:38 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Regard or title) <b>Leo M. Mullen M.D.</b>		22b. ADDRESS <b>4442 Paw Blvd</b>	
22c. DATE SIGNED <b>8-8-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG-9-1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CAVALRY CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <b>8-9-58</b>	
ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO</b>		26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>	

every coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Leo M. Mullen

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 *James W. Hanson* .....

Licensed Embalmer No. *4589* .....

P. O. Address *D. C., No.* .....

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.