

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029288

STATE FILE NUMBER

FILED SEP 5 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3981

S. 300
1-57 0

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Length of stay in 1b <u>19 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>423 Maple Blvd.</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Brunyan</u> Last <u>Uley</u>			4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1958</u>		
--	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-25-1893</u>	9. AGE (In years last birthday) <u>65</u>	FUNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
-------------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Amity Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	---

13a. FATHER'S NAME <u>Wm. Brunyan</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Hollingshead</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Uley</u>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Robert Uley</u>	Address <u>423 Maple N.C. Mo.</u>
--	-------------------------------------	-------------------------------------	-----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Atherosclerotic Cerebral Artery Disease</u>	<u>years</u>
	DUE TO (c) _____	<u>3 3/4</u>

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 checked="" type="checkbox"/> NO <input 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 _____ 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 _____
---	--	--	--

21. I attended the deceased from <u>10-5-56</u> to <u>8-15-58</u> and last saw her alive on <u>8-15-58</u> Death occurred at <u>10:10 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Robert L. Ward, M.D.</u> (Doctor or title)	22b. ADDRESS <u>4126 St John</u>	22c. DATE SIGNED <u>8-15-58</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-20-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
--	-------------------------------	---	--

24. FUNERAL DIRECTOR <u>C.H. Blackman & Son Inc.</u>	ADDRESS <u>H.C. Embelzer's Statement on Reverse Side</u>	25. DATE RECD. BY LOCAL REG. <u>8-18-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
---	---	--	---

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Robert L. Ward

All diseases in Part I must be causally related.

Dr. Robert W. a
4126 E. 9th
K.C. Mo.



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 *W.C. Reine*

Licensed Embalmer No. *4879*
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.