

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029369
STATE FILE NUMBER

FILED AUG 26 1958 Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 348

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) OR TOWN <u>Independence Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD. 4, 1958 22 Mo</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>RFD #4</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY FRANCES CARLYLE</u>			4. DATE OF DEATH Month Day Year <u>Aug 12 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1870</u>	9. AGE (In years last birthday) <u>87</u>	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) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Johnson Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Sideon Maloney</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann</u>	14. NAME OF HUSBAND OR WIFE <u>Gris Carlyle</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Miss Bernice Ryland, Independence Mo</u>
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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) <u>Arteriosclerotic H disease & cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arterial sclerosis</u>		<u>15 yrs.</u>
DUE TO (c) <u>Hangover both feet & ankles.</u>		<u>5 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 May 57 to 8/13/58 and last saw her/him alive on 8/19/58
Death occurred at Home on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. L. Biggs, M.D.</u>	22b. ADDRESS <u>Raytown, 33, Mo</u>	22c. DATE SIGNED <u>8/13/58</u>
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23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>burial</u>	23b. DATE <u>Aug 15, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Raytown, Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Charles H. Hopp, Holden Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-15-58</u>	26. REGISTRAR'S SIGNATURE <u>J. W. [Signature]</u>
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Doctor, 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

