

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029383  
STATE FILE NUMBER

FILED SEP 4 1958 Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 26

300  
1-57

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> <sup>7000</sup>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>6905 E 96th Terr</b>		Length of stay in 1b <b>5 mos</b>	d. STREET ADDRESS (If outside, give location) <b>6905 E 96th Terr</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Ethyl</b> Middle <b>Harvey</b> Last <b>Pritchard</b>			4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>58</b>		
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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>Nov 30 1885</b>	9. AGE (In years last birthday) <b>72</b>	FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Printer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	11. BIRTHPLACE (City and state or country) <b>Centerville, Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John C. Harvey</b>	13b. MOTHER'S MAIDEN NAME <b>Lydia Hoover</b>	14. NAME OF HUSBAND OR WIFE <b>- - -</b>
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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>303 05 8943</b>	17. INFORMANT <b>John F. Pritchard, 6905 E. 96th Terr.</b>	Address
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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>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Cerebral Hemorrhage</b>		
DUE TO (c) <b>Hypertension</b> <b>331 X</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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>

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 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
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21. I attended the deceased from <b>10/16/57</b> to <b>8/28/58</b> and last saw <sup>her</sup> alive on <b>8/28/58</b> Death occurred at <b>10:45 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Barbara D. Paul</i> (Degree or title) <b>D.O. 2</b>	22b. ADDRESS <b>10911 71 Hwy, Hickman Mills</b>	22c. DATE SIGNED <b>8-28-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-29-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centerville Cemetery</b>	23d. LOCATION (City, town, or county) <b>MO.</b> (State) <b>Centerville, Indiana</b>
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24. FUNERAL DIRECTOR <b>E.K. George &amp; Sons Inc Grandview</b>	ADDRESS <b>Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>8-28-58</b>	26. REGISTRAR'S SIGNATURE <i>Barbara D. Paul</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Stirling E. Goddard*

Licensed Embalmer No. *4911*  
P. O. Address *Grandview*

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.