

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032646

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4427

FILED OCT 8 1958

1. PLACE OF DEATH
a. COUNTY **Jackson**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **Jackson**

b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits
TOWN **Kansas City** Yes No

c. CITY OR TOWN **KANSAS CITY** Inside Limits
Kansas City Yes No

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb
HOSPITAL OR INSTITUTION **St. Mary's Hospital** 8 yrs

d. STREET ADDRESS (If outside, give location) Reside on Farm
5914 Blue Ridge Blvd Yes No

3. NAME OF DECEASED First Middle Last
DELLA CRA EDWARDS

4. DATE OF DEATH Month Day Year
September 18 1958

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH **October 28 1871** 86

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) 12. CITIZEN OF WHAT COUNTRY?
Housewife Retired **School Board** **Franklin Indiana** **USA**

13a. FATHER'S NAME **James LeMaster** 13b. MOTHER'S MAIDEN NAME **Sarah Surface** 14. NAME OF HUSBAND OR WIFE **William T Edwards**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT Address **Mrs Mary Ellison 5914 Blue Ridge Blvd**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Coronary artery disease** INTERVAL BETWEEN ONSET AND DEATH **years**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **4201 #**

DUE TO (c)

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 NO

Lymphoma of ileum

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 **8-19-58** to **9-18-58** and last saw her alive on **9-17-58**
Death occurred at _____ m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Robert L. Ward, M.D.** 22b. ADDRESS **4126 St John** 22c. DATE SIGNED **9-18-58**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Sept 20 1958** 23c. NAME OF CEMETERY OR CREMATORY **Woodlawn Cemetery** 23d. LOCATION (City, town, or country) (State) **Independence Missouri**

24. FUNERAL DIRECTOR ADDRESS **Sheil Funeral Home Kansas City Mo** 25. DATE RECD. BY LOCAL REG. **9-18-58** 26. REGISTRAR'S SIGNATURE **Wm Minshall**

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Robert L. Ward

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 P. Shul
 Licensed Embalmer No. 4954
 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.

STATEMENT BY LICENSED EMBALMER

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