

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032789

STATE FILE NUMBER

RECORDED SEP 24 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4158

5. 300
1-57

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) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, or institution) BRATON CAMPBELL HOSPITAL OR INSTITUTION BRATON NURSING HOME		Length of stay in 1b 7 YRS	d. STREET ADDRESS (If outside, give location) 4343 JEFFERSON
3. NAME OF DECEASED (Type or print) First ANNA Middle MARY Last KUBALANZA		4. DATE OF DEATH Month AUG Day 31 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV-30-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) WINFIELD, KANS.
13a. FATHER'S NAME FRANK W. SMITH		13b. MOTHER'S MAIDEN NAME BESSIE COGSWELL	14. NAME OF HUSBAND OR WIFE JOHN KUBALANZA
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. 513-01-5594	17. INFORMANT Address JOHN KUBALANZA 4343 JEFFERSON KCMO
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>Tuberculosis - R. Middle Cerebral Artery</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Sclerosis - cerebral vascular system</u> DUE TO (c) <u>Arterio sclerosis - generalized</u>			INTERVAL BETWEEN ONSET AND DEATH 8 days. 4 years. 10 years
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>1950</u> to <u>8-31-58</u> and last saw her alive on <u>8-30-58</u> Death occurred at <u>9:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>P. Byers</u> (Degree or title) D		22b. ADDRESS <u>4635 W. Gaudin, K.C. Mo</u>	22c. DATE SIGNED <u>8-31-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>AUG-31-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>
23d. LOCATION (City, town, or county) <u>WINFIELD</u>		(State) <u>KANSAS</u>	
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS KAN. CITY, MO</u>		25. DATE RECD. BY LOCAL REG. <u>9-1-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

P. L. Byers

All diseases in Part I must be causally related.
No symptoms will be listed.



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 *Chester K Braun*

Licensed Embalmer No. *493*

P. O. Address *K O V 16*

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.