

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032915  
STATE FILE NUMBER

DECEASED OCT 1 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4382

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Prairie Village</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		Length of stay <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>7239 Village Drive</b>

3. NAME OF DECEASED (Type or print) First <b>MRS. RUBY</b> Middle <b>PEED</b> Last <b>PEED</b>			4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>1958</b>	
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1897</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b>8</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Flower Shop</b>	11. BIRTHPLACE (City and state or country) <b>Ashland, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Hairan Calvin</b>	13b. MOTHER'S MAIDEN NAME <b>Hattie Sapp</b>	14. NAME OF HUSBAND OR WIFE <b>E. Otto Peed</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-38-9849</b>	17. INFORMANT <b>E. Otto Peed</b> Address <b>7239 Village Drive</b>
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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>Cerebral Hemorrhage (Intra-ventricular)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arterial Vasomotor Hypertension</b>	
	DUE TO (c) <b>Essential Hypertension</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Essential Hypertension</b>		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.)
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20c. TIME OF INJURY Hour <b>3:15</b> Month <b>Sept</b> Day <b>14</b> Year <b>1958</b> a.m. <b>3:15</b> p.m.
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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 <b>Wynandotte City, Mo.</b>	COUNTY <b>Wagoner</b> STATE <b>Mo.</b>
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21. I attended the deceased from <b>January 1950</b> to <b>Sept. 14, 1958</b> and last saw her alive on <b>10 am. 9-14-58</b> Death occurred at <b>Kansas City, Mo.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Arnold V. Arms</b>	22b. ADDRESS <b>4635 Wynandotte City, Mo.</b>	22c. DATE SIGNED <b>9/15/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 16, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure Und. Co., K. C., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-15-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

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  
Arnold V. Arms

S. 300  
v. 1-57

2-1-0562  
2-7000

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 *Elmo D. Zippert* .....

Licensed Embalmer No. *4817* .....

P. O. Address *Kansas City, 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.