

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033022  
STATE FILE NUMBER  
4523

FILED OCT 15 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4523

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>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2047 Spruce</b>		Length of stay in lb <b>40 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2047 Spruce</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ruby</b> Middle Last <b>Stiver</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>21</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 29 1900</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sales lady</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Paint Store</b>	9. AGE (In years last birthday) <b>58</b> 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) <b>Retired Sales lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paint Store</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Missouri</b>
13a. FATHER'S NAME <b>Isaac Newton Stiver</b>		13b. MOTHER'S MAIDEN NAME <b>Ulysses Grant Lewis</b>	14. NAME OF HUSBAND OR WIFE *****
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>491-22-3981</b>	17. INFORMANT Address <b>Mrs Bertha White (Sister) 2047 Spruce K.C</b>
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>Hemorrhage,</b> DUE TO (b) _____ DUE TO (c) <b>Abdominal ulcer</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Hypertension and Atherosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</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.) <b>5410</b>	
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 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	
21. I attended the deceased from <b>August 15<sup>th</sup> - 58</b> to <b>Sept 24, 1958</b> and last saw her alive on <b>Sept 10, 1958</b> Death occurred at <b>415<sup>th</sup> St</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H.A. Underwood, M.D.</b>		22b. ADDRESS <b>5700 E. 24<sup>th</sup> K.C. Mo</b>	
22c. DATE SIGNED <b>9/22/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1958 September 25</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mrs C.L. Forster Funeral Home Inc. Kansas City, Missouri.</b>		25. DATE RECD. BY LOCAL REG. <b>9-24-58</b>	26. REGISTRAR'S SIGNATURE <b>newman</b>

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  
H. A. Underwood



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 *J. Vigil* .....

Licensed Embalmer No. *3599* .....

P. O. Address *H. C. M. Co.* .....

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.