

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040357

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 246

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>Mo</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Prairie Twp</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Raytown</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson Co Hosp.</b>		Length of stay in 1b <b>4 yrs +</b>	7000 STREET ADDRESS (If outside, give location) <b>86 + Weatherston</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha EMMa Mayers</b>			4. DATE OF DEATH Month Day Year <b>11-8-58</b>		
---	--	--	--	--	--

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>Unknown</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------	---------------------------	---	------------------------------------	---	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home. Springfield Mo.</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	---	--	--

13. FATHER'S NAME <b>Billie Breeding</b>	13b. MOTHER'S MAIDEN NAME <b>Nannie Campbell</b>	14. NAME OF HUSBAND OR WIFE <b>✓</b>
---	---	---

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>None.</b>	17. INFORMANT <b>Records Jackson Co Hosp Idep. Mo</b>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart disease</b> <b>Generalized Arterio-Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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"/>

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>4200</b>
---	---

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	--	------------------------------	--------	-------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Jan 7-1958</b> to <b>Nov 8-58</b> and last saw her <sup>her</sup> alive on <b>Nov 7-58</b> Death occurred at <b>6:30 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <b>Phil H. H. [Signature]</b> (Degree or title)	22b. ADDRESS <b>Lees Summit, Mo.</b>	22c. DATE SIGNED <b>11-8-58</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 12, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvery Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR <b>Langford Funeral Home</b> <b>Lees Summit Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov 12-1958</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
--	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *W B Langford* .....

Licensed Embalmer No. *3133* .....

P. O. Address *215 S. Main* .....

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.