

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044238

STATE FILE NUMBER

FILED JAN 14 1958

Registration District No. _____

149

Primary Registration District No. _____

1002

Registrar's No. _____

6125

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2034 Brighton		Length of stay in lb 35 yrs	d. STREET ADDRESS (If outside, give location) 2034 Brighton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CORDELIA Middle _____ Last LEWIS			4. DATE OF DEATH Month December Day 23 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1 1904	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		10b. KIND OF BUSINESS OR INDUSTRY General Hospital	11. BIRTHPLACE (City and state or country) Brooken Oklahoma	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Bush		13b. MOTHER'S MAIDEN NAME Fannie Watkins		14. NAME OF HUSBAND OR WIFE Herbert Lewis	
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. 497-36-5427	17. INFORMANT Address Mrs Fannie Heck 2034 Brighton K C Mo		
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 Occlusion					INTERVAL BETWEEN ONSET AND DEATH
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 <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.) ITEM 8, 9 CORRECTED		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			BY: 1. AFFIDAVIT OF Informant Chief Clinch Ext. # 2703-40 2. DOCUMENT		
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		COUNTY _____ STATE _____
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Neighborhood Nurses Center (Degree or title) 3			22b. ADDRESS 1034 Baltic Bldg		22c. DATE SIGNED 12-26-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/26/58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR Sheil Fumeral Home Kansas City Mo			25. DATE RECD. BY LOCAL REG. 12-26-58	26. REGISTRAR'S SIGNATURE Neva Marshall	

All diseases in Part I must be causally related. HUGH H. OWENS

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Thomas A. Shul*

Licensed Embalmer No. *4954*
P. O. Address... *HC 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.