

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047017
STATE FILE NUMBER

1958

FILED DEC 30 1958 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 188

1. PLACE OF DEATH a. COUNTY Vernon		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 Washington Twp.		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital # 3		d. STREET ADDRESS (If outside, give location) Unknown	
3. NAME OF DECEASED (Type or print) First Bessie Middle E. Last Otto		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 checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1889
9a. AGE (In years last birthday) 69		9b. MONTHS 7 DAYS 24	9c. IF UNDER 1 YEAR Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Henry Otto	
13b. MOTHER'S MAIDEN NAME Elizabeth Scott		14. NAME OF HUSBAND OR WIFE None	
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. None	
17. INFORMANT Admission papers, State Hospital # 3, Nevada		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) Coronary Vessel Disease DUE TO (c) (Diabetes) Involutional Melancholia	
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 7:40 A.M. Month, Day, Year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 State Hospital # 3, Nevada, Mo.		20g. COUNTY Kansas STATE Missouri	
21. I attended the deceased from 4-25-1955 to 12-23-1958 and last saw her alive on 12-23-1958 Death occurred at 7:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or Title) <i>[Signature]</i>	
22b. ADDRESS State Hospital # 3, Nevada, Mo.		22c. DATE SIGNED 12-23-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 23 Dec. 58	
23c. NAME OF CEMETERY OR CREMATORY Mt. Washington		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR Blackman		25. DATE RECD. BY LOCAL REG. 12-27-1958	
26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		27. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 9 1958
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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 *Lloyd C. McLeod*

- Licensed Embalmer No. *4853*
P. O. Address *McLeod, 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.