

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-047107

STATE FILE NUMBER

6240

FILED JAN 19 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>              |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>KANSAS CITY</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>V. A. Hospital</b> |  | Length of stay in lb<br><b>7 yrs.</b>  | d. STREET ADDRESS (If outside, give location)<br><b>3838 BELLEFONTAINE</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGARET</b> Middle <b>A.</b> Last <b>BAIN</b> |  |  | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>30</b> Year <b>1958</b> |  |  |
|--|--|--|--|--|--|

|                      |                               |   |   |   |  |
|----------------------|-------------------------------|---|---|---|--|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>February 26, 1918</b> | 9. AGE (In years last birthday) <b>40</b><br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____ |  |
|----------------------|-------------------------------|---|---|---|--|

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|---|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nurse</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b> | 11. BIRTHPLACE (City and state or country)<br><b>Monette, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
|---|---|--|---|

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|---|--|--|
| 13a. FATHER'S NAME<br><b>William J. Cox</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mildred Hunter</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Ralph Bain</b> |
|---|--|--|

|   |                                     |   |
|---|-------------------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes, 8-20-51 to 8-22-54</b> | 16. SOCIAL SECURITY NO.<br><b>—</b> | 17. INFORMANT Address<br><b>VA Hospital Official Records, K. C. Mo.</b> |
|---|-------------------------------------|---|

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|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>45.4</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) <b>Polyarteritis nodosa</b> |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                          |  |   |

|   |  |
|---|--|
| 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<br>Hour _____ 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 |
|---|--|--|------------------------------|--------|-------|

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|--|
| 21. I attended the deceased from <b>August 24, 1958</b> to <b>December 30, 1958</b><br>Death occurred at <b>2:45</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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|   |  |                                     |
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| 22a. SIGNATURE (Degree or title)<br><b>J. A. TURNER, M.D.</b> | 22b. ADDRESS<br><b>VA Hospital, Kansas City, Mo.</b> | 22c. DATE SIGNED<br><b>12-31-58</b> |
|---|--|-------------------------------------|

|  |                            |   |  |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>1-1-59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Lukes Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Marshfield Mo.</b> |
|--|----------------------------|---|--|

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|---|----------------------------|---|--|
| 24. FUNERAL DIRECTOR<br><b>Strick + McClure</b> | ADDRESS<br><b>K.C. Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>1-1-59</b> | 26. REGISTRARS SIGNATURE<br><b>Reva Minchell</b> |
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(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 *J. S. Halton*

Licensed Embalmer No. 2744

P. O. Address K. C. M.B.

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.