

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001221

STATE FILE NUMBER

64

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Overland Park	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Golden Age Nursing		d. STREET ADDRESS (If outside, give location) 6621 Glenwood	
3. NAME OF DECEASED (Type or print) First EMMA Middle T. Last BRYAN		4. DATE OF DEATH Month Jan. Day 4, Year 1959	
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 Jan. 24, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hamburg, Iowa
13a. FATHER'S NAME Henry Towns		13b. MOTHER'S MAIDEN NAME Mary Ellen Easterly	14. NAME OF HUSBAND OR WIFE George T. Bryan
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. 486-10-5055A	17. INFORMANT Don T. Bryan Address Kansas City, 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) Acute Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) 332-2			INTERVAL BETWEEN ONSET AND DEATH 5 weeks 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myocardial Degeneration			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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 April 11, 1955 to Jan 4, 1959 and last saw her ^{her} alive on Jan 3, 1959 Death occurred at 2:30 A. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John K. Caldwell MD (Degree or title)		22b. ADDRESS 306 E 12 St. Kansas City, Mo.	
22c. DATE SIGNED 1/5/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-6-59	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Freeman Mortuary ADDRESS Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 1-6-59	26. REGISTRAR'S SIGNATURE Neve Marshall

MEDICAL CERTIFICATION
John K. Caldwell ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Handwritten scribbles and marks in the top right corner.

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*
P. O. Address *K. C. 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.