

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001505

STATE FILE NUMBER

FILED FEB 5 1959 Station District No. 149 Primary Registration District No. 1002 Registrar's No. 304

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1931 LAWN</u>		Length of stay in 1b <u>16 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>1821 LAWN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>George Robert Sandy</u>			4. DATE OF DEATH Month Day Year <u>1 14 59</u>			
--	--	--	--	--	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--------------------------------------	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - GUARD</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>WILCOX ELEC. CO.</u>	11. BIRTHPLACE (City and state or country) <u>TROY, KANS.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>John W. Sandy</u>	13b. MOTHER'S MAIDEN NAME <u>LOWER</u>	14. NAME OF HUSBAND OR WIFE <u>MINNIE R. CRAWFORD</u>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>493-22-9432R</u>	17. INFORMANT <u>MINNIE R. SANDY</u> Address <u>1821 LAWN</u>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <u>Hypertension</u>	<u>4-5 yrs.</u>
	DUE TO (c) <u>Arteriosclerosis and Cardio Hypertrophy 443x</u>	<u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypochromic Anemia and Chronic Bronchitis</u>		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 Month, Day, Year a.m. p.m.		
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 2/15/55 to 1/14/59 and last saw ^{her}him alive on 1/14/59
Death occurred at 10:10 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William P. Adams, D. D.</u>	22b. ADDRESS <u>3221 Independence Ave.</u>	22c. DATE SIGNED <u>1/16/59</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Troy Kans.</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Sheil Funeral Home K.C. Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-16-59</u>	26. REGISTRAR'S SIGNATURE <u>Seval Marshall</u>
--	---------	--	--

300
-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
William P. Adams

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 *Richard E. Carroll*

Licensed Embalmer No. *4829*

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.