

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004222
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 25

FILED FEB 10 1959

300
1-57

1. PLACE OF DEATH a. COUNTY - <u>Vernon</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>Newada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> 3638 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>City Hospital</u>		Length of stay in lb <u>24 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>4517 Virginia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Conyers</u> Last <u>Conyers</u>			4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>59</u>
5. SEX <u>Female</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>Aug. 8, 1934</u>
9. AGE (In years last birthday) <u>24</u>		IF UNDER 1 YEAR Months <u>24</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cheek-But Cleaners</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delux Cleaners</u>	11. BIRTHPLACE (City and state or country) <u>Olivet, Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Kenneth Jesse</u>	
13b. MOTHER'S MAIDEN NAME <u>Rene Casey</u>		14. NAME OF HUSBAND OR WIFE <u>James Conyers</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>James Conyers - Kansas City, Mo.</u>	
17. INFORMANT <u>James Conyers - Kansas City, Mo.</u>		Address <u>4517 Virginia</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>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic nephrosis</u>			
DUE TO (c) <u>Chronic pyelonephritis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>6000</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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>			
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 <u>12-10-58</u> to <u>2-3-59</u> and last saw ^{her} him alive on <u>2-2-59</u> Death occurred at <u>2:30</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Magee M.D.</u> (Degree or title)		22b. ADDRESS <u>El Dorado Springs, Mo</u>	22c. DATE SIGNED <u>2-3-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>El Dorado Spgs, Mo.</u>
24. FUNERAL DIRECTOR <u>Kevin Brothers - El Dorado Spgs, Mo.</u> ADDRESS <u>2-6-1959</u>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Alma G. Perry</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Max W. Beckering*

Licensed Embalmer No. *4696*

P. O. Address *El Dorado*

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.