Health, Welfare Public Service

300 C 1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004871
STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 27

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN: No. Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Memorial Hospital — Length of stay in 1b: 6 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Mo
b. COUNTY: Clay
c. CITY OR TOWN: Liberty 6001 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 310. Mo. st — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: anna Middle: Flo Last: Marsh

4. DATE OF DEATH: Month: Feb Day: 13 Year: 1959

5. SEX: F 1
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-7-1898
9. AGE (In years last birthday): 60
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): Housewife.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Macon. Co. Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Andrew Marsh
13b. MOTHER'S MAIDEN NAME: Susie Walker
14. NAME OF HUSBAND OR WIFE: Never married

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service): no.
16. SOCIAL SECURITY NO.: no.
17. INFORMANT: Charles Marsh Macon Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Infarction, Pons, Brain	6 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Basilar artery thrombosis	6 hrs.
DUE TO (c)	Cerebral Arteriosclerosis	—

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 332X

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 WORK [ ] NOT WHILE AT WORK [ ]
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 2-13-59, to 2-13-59 and last saw her/him alive on 2-13-59
Death occurred at 10:30 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert H Hodge (Degree or title): MD
22b. ADDRESS: 389 Armour Kansas City Mo
22c. DATE SIGNED: 2-14-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-14-59
23c. NAME OF CEMETERY OR CREMATORY: Mt. Salem Cemetery
23d. LOCATION (City, town, or county) (State): Macon Co. Mo

24. FUNERAL DIRECTOR: D.W. Newcomers, N.K.C. ADDRESS:
25. DATE RECD. BY LOCAL REG.: 2-14-59
26. REGISTRAR'S SIGNATURE: Marguerite Hudgens

(Licensed Embalmer's Statement on Reverse Side)

Robert Hodge. MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

REC
FEB 2
CLA
HEALTH

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 .....

Licensed Embalmer No. 4586

P. O. Address .....

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.