

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005474
STATE FILE NUMBER

FILED FEB 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 570

300
-57

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|---|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7104 Bellefontaine | | Length of stay in lb 40 yrs | d. STREET ADDRESS (If outside, give location) 7104 Bellefontaine Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle ELDRIDGE Last CARTER | | | 4. DATE OF DEATH Month Jan Day 29 Year 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 21, 1894 |
| 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Ice Route | | 10b. KIND OF BUSINESS OR INDUSTRY K. C. Ice Co. | 11. BIRTHPLACE (City and state or country) Cabool, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME John Carter | |
| 13b. MOTHER'S MAIDEN NAME Mary Frye | | 14. NAME OF HUSBAND OR WIFE Mrs. Mabel Carter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 486-07-4569 | 17. INFORMANT Address Mrs. Mabel Carter, 7104 Bellefontaine |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of prostate. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). _____ | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 mo. 2-3 years |
| 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 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 | |
| 21. I attended the deceased from 7-20-58 , to 1-29-59 and last saw him alive on 1-28-59 Death occurred at 8 a. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) J. P. McCalla, M.D. | | 22b. ADDRESS 631/2 Raytown Rd. | |
| 22c. DATE SIGNED 1-30-59. | | 23a. BURIAL OR CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE 1-31-1959 | | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery | |
| 23d. LOCATION (City, town, or county) (State) Kansas City, Ma | | 24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar Funeral Home | |
| 25. DATE RECD. BY LOCAL REG. 1-30-59 | | 26. REGISTRAR'S SIGNATURE neva minishell | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
J. P. McCalla

All diseases in Part I must be causally related.

Woodland-Linwood

(Licensed Embalmer's Statement on Reverse Side)

*Dr. J. P. Butler
6512 Regency
Fla 3-3600*

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 *James E. Hackle*
Licensed Embalmer No. *14573*
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.