

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005477

STATE FILE NUMBER

992

FILED MAR 11 1959

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

300

-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>		Length of stay in lb <b>11 days</b>	d. STREET ADDRESS (If outside, give location) <b>2722 Raytown Road</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>C.</b> Last <b>CESSNA</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1881</b>	9. AGE (In years last birthday) <b>77</b> 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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>George McClure</b>		13b. MOTHER'S MAIDEN NAME <b>Mary F. Franks</b>		14. NAME OF HUSBAND OR WIFE <b>Mr. Ira B. Cessna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. Ira B. Cessna</b> Address <b>2722 Raytown rd. K.C. MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Head Injury: Subdural Hematoma</b>			<b>12 days</b>
		DUE TO (c) _____			<b>99-2-1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>Fell - 3-4 steps.</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>2 8 59</b>			LOCATION <b>123</b>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>		COUNTY <b>Jackson</b> STATE <b>Mo.</b>
21. I attended the deceased from <b>2-8-59</b> to <b>2-20-59</b> and last saw her alive on <b>2-20-59</b> Death occurred _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert W. Forsyth</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>411 Nichols Rd.</b>		22c. DATE SIGNED <b>2 20 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 23, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2-22-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

Robert W. Forsyth MD

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *R. Kenneth Patterson* .....

Licensed Embalmer No. *4697* .....

P. O. Address *Indep. 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.