Health, Welfare Public Service

300 -57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005574

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 784

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): KANSAS CITY — Inside Limits: Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3432 Park — Length of stay in Ib: 45 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3432 Park — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: MARION Middle: MARTIN Last: GRAHAM

4. DATE OF DEATH Month Day Year: February 7, 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED X **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 25, 1892

9. AGE (In years last birthday): 66 yrs. — 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): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Ft. Scott, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John Graham

13b. MOTHER'S MAIDEN NAME: Celia Martin

14. NAME OF HUSBAND OR WIFE: Bertha Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 495-05-8042

17. INFORMANT: Bertha Graham Address: 3432 Park Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Infarction
DUE TO (c) Hypertensive Cardio-Vascular Disease
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

19. WAS AUTOPSY PERFORMED? YES ☐ 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 12-6-56, to 2-7-59 and last saw him alive on 1-26-59
Death occurred at 4:55 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Royall B. Fleming, M.D.

22b. ADDRESS: 1433 E-19th St

22c. DATE SIGNED: 2-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2-11-59

23c. NAME OF CEMETERY OR CREMATORY: National

23d. LOCATION (City, town, or county) (State): Leavenworth, Kansas

24. FUNERAL DIRECTOR ADDRESS: Watkins Bros. Funeral Home 18th & Benton

25. DATE RECD. BY LOCAL REG.: 2-11-59

26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

Royall B. Fleming

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ....Bruce R. Watkins.....

Licensed Embalmer No. ....450.....

P. O. Address ..18th & Benton

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.