

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005621

STATE FILE NUMBER

FEB 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 702

300
-57 C

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) Kansas City		c. CITY OR TOWN Kansas City	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital 53 years		d. STREET ADDRESS (If outside, give location) 5209 Independence Ave.	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MISS Middle ANNA Last HUMPHREY			4. DATE OF DEATH Month February Day 3 Year 1959		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1874	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min.
----------------------	-------------------------------	---	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Dept. Store Woolf Brothers	11. BIRTHPLACE (City and state or country) Syracuse, Ohio	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME David Humphrey	13b. MOTHER'S MAIDEN NAME Sarah A. Collins	14. NAME OF HUSBAND OR WIFE None
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 486-01-2013	17. INFORMANT Helen Converse, 5209 Independence Ave.
--	---	--

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 Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 6 days
DUE TO (b) Coronary Occlusion		6 days
DUE TO (c) Arteriosclerotic Heart Disease		Years

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 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 5:25 Month 6 Day 59 Year 59 a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION K.C., Mo.	COUNTY	STATE
--	--	--	--------	-------

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 K.C., Mo.	COUNTY	STATE
--	--	--	--------	-------

21. I attended the deceased from 3-6-54 to 2-3-59 and last saw her alive on 2-3-59 Death occurred at 5:25 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Robert L. Ward M.D.</i>	22b. ADDRESS 4126 St. John, K.C., Mo.	22c. DATE SIGNED 2-5-59
--	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 6, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	----------------------------------	--	---

24. FUNERAL DIRECTOR Stine & McClure Und. Co., K.C., Missouri	25. DATE RECD. BY LOCAL REG. 2-6-59	26. REGISTRAR'S SIGNATURE <i>neva menshall</i>
---	---	---

MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Robert L. Ward
 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 *William M. Turner*

Licensed Embalmer No. *4648*
P. O. Address *Kansas City, 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.