

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-0058863
STATE FILE NUMBER

FILED FEB 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 641

300
1-57

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		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital	
Length of stay in lb 58 yrs.		d. STREET ADDRESS (If outside, give location) 322 Porte Cimi Pas	
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last SAVAGE		4. DATE OF DEATH Month Feb. Day 2 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 7-12-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if unpaid) Commercial artist		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (City and state or country) Kansas City, Mo.
13a. FATHER'S NAME Don Savage		13b. MOTHER'S MARDEN NAME Susan M. Manemer	14. NAME OF HUSBAND OR WIFE Emily Savage
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. 495-01-1825	17. INFORMANT Address Emily Savage 322 Porte Cimi Pas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Portal Cirrhosis of the Liver DUE TO (c) Lymphosarcoma - Neck glands - surgically resected May 1956.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 1-30-59 to 2-1-59 and last saw her/him alive on 2-1-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John H. Wheeler</i> (Degree or title) M.D.		22b. ADDRESS 411 Nichols Road K. C. Mo.	
22c. DATE SIGNED 2-2-59			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 2-4-59	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Kansas City Mo.	
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 2-3-59	
ADDRESS Woodland Linwood		26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION
John H. Wheeler

11 25

2-5 PM

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 *Arthur Eugene Har...*

Licensed Embalmer No. *4912*
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.