

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006031

STATE FILE NUMBER

#202
FILED FEB 25 1959

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY Jackson Blue		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before a. STATE Missouri COUNTY Jackson (Division))	
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 1000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 620 Overton		Length of stay in 1b 29 Yrs	d. STREET ADDRESS (If outside, give location) 620 Overton
3. NAME OF DECEASED (Type or print) First Middle Last Marion L. Dukes		4. DATE OF DEATH Month Day Year 2 18 1959	
5. SEX Female	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 3/18/1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Unknown - Maine
13a. FATHER'S NAME Unknown - Dix		13b. MOTHER'S MAIDEN NAME Blanche Sprague	14. NAME OF HUSBAND OR WIFE VOLLIE R. DUKES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address VOLLIE R. DUKES - 620 Overton Independence, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Hemorrhage, gastrointestinal Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Enlarged varices YES DUE TO (c) Portal venous thrombosis (Banti's syndrome) YES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None 2980			19. INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
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 5-28-58 to 2-18-59 and last saw her alive on 2-18-59 Death occurred at 5:30 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. Vincent Green, M.D. (Doctor or title)		22b. ADDRESS 10901 W. 1st Rd Independence, Mo.	22c. DATE SIGNED 2-18-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-19-59	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Floral Hills Chapels		25. DATE RECD. BY LOCAL REG. 2-19-59	26. REGISTRAR'S SIGNATURE James H. Gray

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1959 8 2 831

1959 8 2 831

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 Forrest D. Boldenow

Licensed Embalmer No. 4714

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.