

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009277
STATE FILE NUMBER

FILED MAR 19 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1079

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. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 910 WARD PARKWAY		d. STREET ADDRESS 910 WARD PARKWAY	
3. NAME OF DECEASED (Type or print) First Middle Last MAYME BEAN		4. DATE OF DEATH Month Day Year FEBRUARY 25, 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 NOVEMBER 13, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 74	11. BIRTHPLACE (City and state or country) ELKADER, IOWA
13a. FATHER'S NAME JOHN FRIEND	13b. MOTHER'S MAIDEN NAME CATHERINE REFLE	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
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. 486-03-8983	17. INFORMANT LYLE H. BEAN, SR.	
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	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Acute Coronary Occlusion			
DUE TO (c) Arteriosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus.		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 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 8-20-41 , to 2-25-59 and last saw her alive on 2-17-59 Death occurred at 5:30 A. 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 2-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE FEB. 28, 1959	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 2-27-59	26. REGISTRAR'S SIGNATURE <i>Irlva Marshall</i>

(Licensed Embalmer's Statement on Reverse Side)

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All entries in Part I must be causally related.

John H. Wheeler USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION



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 *Basil V. Honey*

Licensed Embalmer No. *4724*
P. O. Address *A.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.