

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009494
STATE FILE NUMBER
1548

APR 8 1959 Registration District No. 147 Primary Registration District No. 1002 Registrar's No.

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 1311 Jackson		d. STREET ADDRESS 1311 Jackson	
3. NAME OF DECEASED (Type or print) Druesiller		4. DATE OF DEATH Month 3 Day 20 Year 59	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1906	
9. AGE (In years last birthday) 52		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and state or country) Wynn, Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Will Jones		13b. MOTHER'S MAIDEN NAME Belle Eason	
14. NAME OF HUSBAND OR WIFE Horace Kearney		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Horace Kearney		Address 1311 Jackson	
18. CAUSE OF DEATH (Give only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Congestion & Edema DUE TO (b) Myocardial Insufficiency DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a), (b), and (c).		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 Month, Day, Year 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 _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Deputy Coroner L. M. Tillman		22b. ADDRESS 1618 Lydia Ave	
22c. DATE SIGNED 3/23/59		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-59	
23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn		23d. LOCATION (City, town, or county) Kansas City Mo.	
24. FUNERAL DIRECTOR Lawrence A. Jones		25. DATE RECD. BY LOCAL REG. 3-25-59	
ADDRESS 2304 Vine		26. REGISTRAR'S SIGNATURE neva minshall	

L. M. Tillman 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 *[Handwritten Signature]*

Licensed Embalmer No. *6422*

P. O. Address *730 Hill*

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.