

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009724

STATE FILE NUMBER

FILED MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1094

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO 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 919 Cherry		d. STREET ADDRESS (If outside, give location) 919 CHERRY	
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle GEORGE Last WARD		4. DATE OF DEATH Month 2 Day 26 Year 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-30-80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and state or country) IOWA
13a. FATHER'S NAME Uhlen		13b. MOTHER'S MAIDEN NAME Uhlen	14. NAME OF HUSBAND OR WIFE —
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. no	17. INFORMANT Mrs Virginia Reese Address 919 cherry 1012 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) DECOMPENSATED COR PULMONALE with CIRCULATORY FAILURE			INTERVAL BETWEEN ONSET AND DEATH FEW MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CHRONIC PULMONARY EMPHYSEMA			UKN.
DUE TO (c) CHRONIC BRONCHIAL ASTHMA			UKN.
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"/> 2
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) X X X X		
20c. TIME OF INJURY Hour X a.m. X p.m. X	X X X X		
20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, street, office bldg, etc.) X X X X	20f. CITY, TOWN, OR LOCATION X X X X	STATE X X X X
21. I attended the deceased from Mar. 2 1955 , to Feb. 26 1959 and last saw him alive on Feb. 26, 1959 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert N. Clarke, D.O. (Degree or title)		22b. ADDRESS 3353 E. 27th St., K.C. Mo.	22c. DATE SIGNED Feb. 27 1959
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE 2/28/59	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary	23d. LOCATION (City, town, or county) (State) Kansas City Mo
24. FUNERAL DIRECTOR SHEIL FUNERAL HOME K.C. MO		25. DATE REC'D. BY LOCAL REG. 2-27-59	26. REGISTRAR'S SIGNATURE Neva Marshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Harold J. Reie*

Licensed Embalmer No. *4998*

P. O. Address *Kansas City*

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.