

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017851
STATE FILE NUMBER

JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2382

300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY JOHNSON	
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 PRAIRIE VILLAGE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSP		Length of stay in 1b 1 Week	d. STREET ADDRESS (If outside, give location) 7530 SAGAMORE
3. NAME OF DECEASED (Type or print) First Middle Last ADOLAPHUS WESLEY MATER			4. DATE OF DEATH Month Day Year MAY 12 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 APRIL 17-1982 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union Dist. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Western Union	11. BIRTHPLACE (City and state or country) Kellerton Iowa
13a. FATHER'S NAME CYRUS E. MATER		13b. MOTHER'S MAIDEN NAME FANNIE MANNING	14. NAME OF HUSBAND OR WIFE MRS A.W. Willie Mater
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 486-01-7014	17. INFORMANT <input checked="" type="checkbox"/> Address MRS A.W. MATER 7530 SAGAMORE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatitis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) 5870	
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 Mar 31, 1959 to date and last saw her alive on 5/12/59 Death occurred at 10 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dm Black		22b. ADDRESS M.D. 924 Professional Bldg.	22c. DATE SIGNED 5/13/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE May 13-1959	23c. NAME OF CEMETERY OR CREMATORY Shawnee Cem	23d. LOCATION (City, town, or county) (State) Shawnee KANSAS
24. FUNERAL DIRECTOR LATES ADDRESS 1901 OIATHE BLDG KANSAS CITY 3-MAN		25. DATE RECD. BY LOCAL REG. 5-13-59	26. REGISTRAR'S SIGNATURE Neva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Don A. Black

All diseases in Part I must be causally related.

DR. BLACK
924 PROF Bldg.

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 *Paul R. Williamson*

Licensed Embalmer No. *5009*

P. O. Address *Overland Park*

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.

