

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017852

STATE FILE NUMBER

FILED MAY 29 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2181

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 WYANDOTTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St MARYS		d. STREET ADDRESS (If outside, give location) 1231 Southwest Blvd	
3. NAME OF DECEASED (Type or print) Rachal Emma Mathias		4. DATE OF DEATH Month Day Year APRIL 29-1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSIC TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SELF	9. AGE (In years last birthday) 91
11. BIRTHPLACE (City and state or country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME DANIEL MATHIAS		13b. MOTHER'S MAIDEN NAME Leah JENKINS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CORA OSWALD		Address K.C. Kan.	
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 Cardiac Failure - DUE TO (b) Cerebral Thrombocia Left DUE TO (c) Partial Hemiplegia Right.			INTERVAL BETWEEN ONSET AND DEATH 29 Days 29 Days 29 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis - 332X			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.) (none)	
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 May 1952, to 4-29-59 and last saw her alive on 4-29-59 Death occurred at 8:55 Pm on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James W Downey M.D.		22b. ADDRESS 425 E 63rd K.C. Mo.	
22c. DATE SIGNED 4-30-59			
23a. DATE MAY 2-1959		23b. NAME OF CEMETERY OR OREMATORY Forest Hill Cem.	
23c. LOCATION (City, town, or county) Kansas City MO			
24. FUNERAL DIRECTOR Wates		25. DATE RECD. BY LOCAL REG. 5-1-59	
ADDRESS 1901 Olive Blvd Kansas City, Mo.		26. REGISTRAR'S SIGNATURE Neva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

James W. Downey

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 *Paul R. Williams*

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.