

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017992

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2541

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Miami	
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 Oswatomie Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hospital		Length of stay in lb 6 mo.	d. STREET ADDRESS (If outside, give location) 513 First St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Margaret Middle A. Last Tuel			4. DATE OF DEATH Month May Day 20 Year 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 Dec. 20, 1887	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____
-------------------------	----------------------------------	---	--	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	-----------------------------------	---	---

13a. FATHER'S NAME Frank H. Tuel		13b. MOTHER'S MAIDEN NAME Cora P. Hill		14. NAME OF HUSBAND OR WIFE None	
--	--	--	--	--	--

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. none	17. INFORMANT Address Mrs. Carie L. Brown 5621 Chestnut K. C. 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) Cor Pulmonale & Ht failure				INTERVAL BETWEEN ONSET AND DEATH 3 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of Rt Breast & metastases to		1 yr.	
	DUE TO (c) Lungs, Bones & Meninges.		6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Month, Day, Year _____			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
---	--	--	--	--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 3/10/59 to 5/20/59 and last saw her/him alive on 5/20/59 Death occurred at St Joseph Hosp. K.C. Mo. on the date stated above; and to the best of my knowledge, from the causes stated.					
--	--	--	--	--	--

22a. SIGNATURE A. L. Biggs, M.D. (Degree or title)		22b. ADDRESS Raytown, MO		22c. DATE SIGNED 5/21/59	
--	--	------------------------------------	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/21/59		23c. NAME OF CEMETERY OR CREMATORY Elmdale		23d. LOCATION (City, town, or county) (State) Oswatomie Kansas	
---	--	-----------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR Stine & McClure		ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 5-21-59		26. REGISTRAR'S SIGNATURE Neva Marshall	
--	--	-----------------------------	--	--	--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
H. L. Biggs

All diseases in Part I must be causally related.

*File 3-1192
with Spring office
April 12, 30 P.M.*

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 *William M. Turner*

Licensed Embalmer No. *4648*
P. O. Address *Lawrence City, 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.