

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020725

STATE FILE NUMBER

FILED JUN 25 1959 Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLAY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORTH KANSAS CITY</b>		c. CITY OR TOWN <b>NORTH KANSAS CITY</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MEMORIAL HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>820 E 21<sup>ST</sup> AVE.</b>	
Length of stay in lb <b>Life</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>William E. MACKEN</b>			4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 30 1871</b>	9. AGE (In years last birthday) <b>87</b>	F UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE - INSURANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CLAY Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>ALBERT MACKEN</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Jane CURRY</b>		14. NAME OF HUSBAND OR WIFE <b>NORA MACKEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>514-40-0291</b>		17. INFORMANT Address <b>MRS. WAYNE KEITNER 820 E 21<sup>ST</sup></b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease - decompensated</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic coronary artery</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 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 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 **Jun. 19 56** to **June 19 59** and last saw <sup>him</sup> alive on **June 14, 1959**  
Death occurred at **5:30** A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Robert H. Hodges</b> (Degree or title)	22b. ADDRESS <b>379 Arroyo Rd Kansas City Mo</b>	22c. DATE SIGNED <b>6/15/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MARIAH CEM</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO</b>
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24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons - N.K.C.</b>	25. DATE RECD. BY LOCAL REG. <b>6-16-59</b>	26. REGISTRAR'S SIGNATURE <b>Marquitta Hudson</b>
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Health, & Welfare Public Service

300 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
**(Robert H. Hodges, M.D.)**

MEDICAL CERTIFICATION

940

*th. Nodge*

695 9 10P



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 *John V. Hendricks* .....  
Licensed Embalmer No. *4848* .....  
P. O. Address *K. L. ...* .....

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.