

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021310

STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. 149

Primary Registration District No. 1002

Registration No. 3162

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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MISSION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location of residence) HOSPITAL OR INSTITUTION GEORGE M. CANINE NURSING HOME 5905 E. 93 st.			d. STREET ADDRESS (If outside, give location) 5306 W. 67TH STREET		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ALLIE DRENNEN			4. DATE OF DEATH Month Day Year JUNE 27, 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1868	9. AGE (In years last birthday) 90 YRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MUSCATINE, IOWA		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME SAMUEL E. REARY		13b. MOTHER'S MAIDEN NAME SARAH UNKNOWN		14. NAME OF HUSBAND OR WIFE THOMAS E. DRENNEN	
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 VERNE E. DRENNEN 5306 E 57 STREET MISSION		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chyphalomalacia</i> DUE TO (b) <i>Asteris Adentosis - Senility</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 7 months
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 <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 1947 to 6/27/59 and last saw her alive on 6/25/59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Edson C. Carrier, M.D.</i>			22b. ADDRESS 242 Plaza Med Bldg		22c. DATE SIGNED 6/27/59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JUNE 29, 1959	23c. NAME OF CEMETERY OR CREMATORY MADEL HILL CEM		23d. LOCATION (City, town, or county) (State) KANSAS CITY, KANSAS	
24. FUNERAL DIRECTOR D.W. Newcomer's son		ADDRESS 14. E mo	25. DATE RECD. BY LOCAL REG. 6-29-59	26. REGISTRAR'S SIGNATURE Neva Minshall	

Edson C. Carrier
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Regan F. Fuller*

Licensed Embalmer No. *4818*
P. O. Address. *K. C. 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.