

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021466

9  
FILED JUN 17 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NUMBER

Registrar's No. 2688

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RESEARCH HOSP.</b>			Length of stay in lb <b>59 YRS.</b>		d. STREET ADDRESS <b>8500 SNI A BAR RD.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED. (Type or print) First Middle Last <b>CLARENCE E. KARR</b>				4. DATE OF DEATH Month Day Year <b>MAY 29, 1959</b>				
5. SEX <input type="checkbox"/> MALE	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 11, 1885</b>		9. AGE (In years last birthday) <b>74 YRS.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER C. E. KARR REAL ESTATE CO.</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CLARENCE, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>JOSEPH KARR</b>			13b. MOTHER'S MAIDEN NAME <b>ELIZABETH SILL</b>		14. NAME OF HUSBAND OR WIFE <b>RUBY N. KARR</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>493 22 1749</b>		17. INFORMANT Address <b>hospital records</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>Brain tumor</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hemorrhage into tumor</b>						<b>3 months</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) <b>atelectasis</b>						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 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 <b>Oct 1951</b> to <b>29 May 59</b> and last saw him alive on <b>29 May 59</b> . Death occurred at <b>11:30 AM</b> m on the date stated above; and to the best of my knowledge, from the cause stated.								
22a. SIGNATURE (Degree or title) <b>Jack M. Davis M.D.</b>				22b. ADDRESS <b>Raytown Mo</b>		22c. DATE SIGNED <b>19 June 59</b>		
23a. BURIAL, CREMATION, REBURIAL (Specify) <b>BURIAL</b>		23b. DATE <b>JUNE 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>		23d. LOCATION (City, town, or county) <b>KANSAS CITY, MO.</b>			
24. FUNERAL DIRECTOR <b>D. W. Comerio Sons</b>			ADDRESS <b>K.C. MO</b>	25. DATE RECD. BY LOCAL REG. <b>6-1-59</b>		26. REGISTRAR'S SIGNATURE <b>Melva Minshall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Jack M. Davis

VS JUN - 8 1960

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 *Vern Lawler* .....

Licensed Embalmer No. *4915* .....

P. O. Address *K.G.M.O.* .....

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.