

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021861

FILED JUN 29 1959

Registration District No. 150 Primary Registration District No. 5572 STATE FILE NUMBER 141 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Rural Prairie		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Jackson Co. Hosp.		Length of stay in lb. 4 days	d. STREET ADDRESS (If outside, give location) 1314 S. Pope

3. NAME OF DECEASED (Type or print) First **Jettie** Middle Last **Neath**

4. DATE OF DEATH Month **June** Day **9** Year **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 Mar 25, 1881	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Cedar Rapids, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Joseph Bloodworth	13b. MOTHER'S MAIDEN NAME Sarah Starr	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. 449-10-22480	17. INFORMANT Address Earl Dumbek 1314 S. Pope Indpls
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebro-Vascular Accident, arterio-sclerosis**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) **331x**

19. WAS AUTOPSY PERFORMED? YES NO

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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from **6-5-59** to **6-9-59** and last saw her alive on **6-9-59**
Death occurred at **3:30** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Philip Japer M.D.	22b. ADDRESS West Summit Mo	22c. DATE SIGNED 6/9/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	23b. DATE 6/12/59	23c. NAME OF CEMETERY OR CREMATORY Mound Grove	23d. LOCATION (City, town, or county) (State) 7. River Blvd. Indpls
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24. FUNERAL DIRECTOR ADDRESS Poland R. Spinks Indpls 29	25. DATE RECD. BY LOCAL REG. 6-12-59	26. REGISTRAR'S SIGNATURE D.B. Langford
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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 *Poland R. Sparks*

Licensed Embalmer No. *3647*

P. O. Address *Indef. Ind.*

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.