

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023913

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 101

300
1-57

1. PLACE OF DEATH a. COUNTY <u>VERNON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON TOWNSHIP</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STATE HOSP. #3</u>		Length of stay in lb <u>4 MONTHS, 4 DAYS</u>		323 STREET ADDRESS <u>1819 NORTH</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>C.</u> Last <u>HARTMAN</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 26. 1879</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>SEDALIA MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>ELLEN HAASE</u>		14. NAME OF HUSBAND OR WIFE <u>ROSE HARTMAN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>500-12-2536</u>		17. INFORMANT Address <u>HOSP. RECORDS STATE HOSP. #3 NEVADA MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 WEEKS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u>	
						DUE TO (c) <u>4500</u>	
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 <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>							
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 <u>JAN. 30. 1959</u> to <u>MAY 6. 1959</u> and last saw ^{her} him alive on <u>MAY 6. 1959</u> Death occurred at <u>4:47 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)				22b. ADDRESS <u>STATE HOSP. #3 NEVADA MO</u>		22c. DATE SIGNED <u>6-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/9/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Oliver</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 Troost</u>			25. DATE RECD. BY LOCAL REG. <u>6-9-1959</u>		26. REGISTRAR'S SIGNATURE <u>Orma E. Ferry</u>		

(Licensed Embalmer's Statement on Reverse Side)

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
MEDICAL CERTIFICATION

VS
AUG 16 1930

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 *J. T. Crowell*

Licensed Embalmer No. *4904*

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.