

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-025046

## FILED VS AUG 1 0 1959 49

## 3614

STATE FILE NUMBER

 Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</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>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>50 yrs.</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>Trinity Lutheran Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>630 South Ash</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>L. C.</u> Last <u>Clardy</u>			4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Re. Lawyer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis - Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Benjamin F. Clardy</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Beard</u>	14. NAME OF HUSBAND OR WIFE <u>Dora Bell Clardy</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Helen Humphrey 628 S. Ash, K.C. MO</u>
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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) <u>S starvation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>4 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cancer of S. stomach</u>	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from April 5 9 to July 26 59 and last saw her/him alive on 25 July 59  
Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert M. Myers M.D.</u>	22b. ADDRESS <u>1025 Quail Blv.</u>	22c. DATE SIGNED <u>27 July 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
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24. FUNERAL DIRECTOR <u>Roland R. Speaks Independence, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Alva Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Robert M. Myers

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Willie Fessel

Licensed Embalmer No. 4690

P. O. Address Indy, IN

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.