

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-025053

### FILED VS JUL 31 1959

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 3439 STATE FILE NUMBER

INDEXED

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>		Length of stay in 1b <b>2 yrs.</b>	c. CITY OR TOWN <b>Kansas City,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3661 Campbell Street.</b>			* Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3661 Campbell Street.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Walker</b> Last <b>Clymer</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14,</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1879</b>	9. AGE (last birthday) <b>79 YRS.</b>	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 24 HR Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her Self</b>	11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>Charles Ewing Brown</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>Lewis Clymer</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>515 05 8240</b>	17. INFORMANT Address <b>K. C. MO.</b> <b>LILLIAN LARSH 3661 CAMPBELL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH <b>about 3 years</b>
IMMEDIATE CAUSE (a) <b>Consecutive heart failure</b>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertosis</b>					
DUE TO (c) <b>Senility</b>					
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.	Month, Day, Year _____				
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>August 24 1957</b> to <b>June 11 1959</b> and last saw her <sup>him</sup> alive on <b>June 11, 1959</b> Death occurred at <b>D</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title) _____			22b. ADDRESS <b>3100 Troost Kansas City 9 Mo</b>		22c. DATE SIGNED <b>7/14/59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JULY 14, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM</b>	23d. LOCATION (City, town, or county) (State) <b>TOPEKA KANSAS</b>		
24. FUNERAL DIRECTOR <b>D. W. Newcomer's Sons</b>		ADDRESS <b>1331 Brush Creek R. C. Missouri.</b>	25. DATE RECD. BY LOCAL REG. <b>7-14-59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

BY AFFIDAVIT OF S. Van Noy 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed *D. Earl Leavelle*

Licensed Embalmer No. 7915

P. O. Address KC. 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.