

**R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 28 1959

59-028459

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>6 1/2 yrs.</u>	c. CITY OR TOWN <u>Excelsior Springs</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>Excelsior Springs Hospital</u>			d. STREET ADDRESS (If outside, give location) <u>815 Wilhite</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joy</u> Middle <u>Zelle</u> Last <u>Marker</u>			4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1930</u>	9. AGE (last birthday) <u>29</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Psychiatric Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Marys Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Daniel Marker</u>		13b. MOTHER'S MAIDEN NAME <u>Oneita Udenstock</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 8-57 to 1-59</u>		16. SOCIAL SECURITY NO. <u>511-28-1553</u>	17. INFORMANT <u>Oneita Marker, 815 Wilhite, Ex. Spr., Mo.</u> Address			
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>Cerebral Edema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Cholemic Nephrosis</u>					<u>48 hrs</u>	
DUE TO (c) <u>Acute Hepatitis</u>					<u>1 week</u>	
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 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 <u>1955</u> to <u>August 7, 1959</u> and last saw her alive on <u>August 7, 1959</u> Death occurred at <u>7:50</u> p.m. of the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Ralph L. Nicholson, M.D.</u>			22b. ADDRESS <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>8/8/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arvoniam Cemetery</u>	23d. LOCATION (City, town, or county) <u>Arvoniam, Kansas</u>		(State)	
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> ADDRESS <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>8/22/59</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Excelsior Springs, Missouri (Embalmer's Statement on Reverse Side)

390: 8 8 317

FEB 10 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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Lindee Jarman

Licensed Embalmer No. 4589

Excelsior Springs  
City Address

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.