

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-029204

FILED VS SEP 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4199 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>20 years</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Benton Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>504 Benton</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1122 Penn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alma</u> Middle <u>Mabel</u> Last <u>Merritt</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>22</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Fm</u>	<b>6. COLOR OR RACE</b> <u>Wh</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1902</u> <u>April 27</u>	<b>9. AGE (last birthday)</b> <u>57</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Eagleville, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>Adam Herring</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Marvetta Tripp</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Dale Merritt</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Wm. Fessler Nevada, Missouri</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> (b) <u>Arteriosclerosis</u> <u>6 years</u> (c) <u>Diabetes</u> <u>8 years</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>2-1-59</u> <u>11am</u> <b>to</b> <u>8-22-59</u> <b>and last saw her</b> <u>8-22-59</u> <b>live on</b> <u>8-22-59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Frank Paul Laurencey M.D.</u>			<b>22b. ADDRESS</b> <u>428 S White Ave</u>		<b>22c. DATE SIGNED</b> <u>8-22-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Moore Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Nevada Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>FERRY FUNERAL HOME NEVADA, MISSOURI</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>8-28-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Marshall</u>		

DOCUMENT

BY AFFIDAVIT OF Frank Paul Laurencey M.D. Medical Certification

JUL 1 9 1962

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**STATEMENT BY LICENSED EMBALMER**

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

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

Signed B. E. Weiler

Licensed Embalmer No. 4072

P. O. Address L. C. 87

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