DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-029361
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3778

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY — Length of stay in 1b: 44yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 5829 MCGEE 15 yrs. — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5829 MCGEE — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Marian Alice Middle: ~~MARION~~ Last: ~~BLAKSLEE~~ WALKER

4. DATE OF DEATH: Month AUG Day 2, Year 1959

5. SEX: female
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1 29 1898
9. AGE (last birthday): 61 yrs.
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): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): ROCK ISLAND ILL
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: GEORGE C. BLAKESLEE
13b. MOTHER'S MAIDEN NAME: ELLA ~~BLAKESLEY~~ BLAKSLEY
14. NAME OF HUSBAND OR WIFE: JAMES K. WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JAMES K. WALKER Address: 5829 MCGEE K. C. MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c) Multiple Myeloma
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 1959, to 8-2-59 and last saw her/him alive on 7-15-59
Death occurred at 2:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. K. Skillman MD
22b. ADDRESS: 4635 Wyandotte, K.C. Mo.
22c. DATE SIGNED: 8-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE: AUG 5, 1959
23c. NAME OF CEMETERY OR CREMATORY: D. W. NEWCOMER'S SONS
23d. LOCATION (City, town, or county) (State): KANSAS CITY MO.

24. FUNERAL DIRECTOR ADDRESS: D. W. NEWCOMER'S SONS K. C. MO.
25. DATE RECD. BY LOCAL REG.: 8-4-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Informant

MEDICAL CERTIFICATION R. K. Skillman

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert L. Savage

Licensed Embalmer No. 4 81 2

P. O. Address Kansas Ci

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