

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032692

FILED VS **OCT 13 1959**

146

Registration District No. **3026**

Primary Registration District No. **431**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 22 Yrs		c. CITY OR TOWN Independence		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2445 Claremont Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alma Middle Scott Last Propst				4. DATE OF DEATH Month October Day 4 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-27-1899	9. AGE (last birthday) 59	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) School Teacher			10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (City and state or country) Condon Oregon		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Otis W. Propst			13b. MOTHER'S MAIDEN NAME Florence Davidson			14. NAME OF HUSBAND OR WIFE Mrs. Arville Propst		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 490-16-1453		17. INFORMANT Address Mrs. Arville Propst 2445 Claremont Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid & left cerebral hemorrhage due to ruptured Aneurysm of circle of Willis.							INTERVAL BETWEEN ONSET AND DEATH 14 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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		
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 _____ 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 2-23-59 to 10-4-59 and last saw ^{her} him alive on 10-4-59 Death occurred at 9:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Drs. Grabske & Link (Degree or title) <i>Vance E. Link MD</i>				22b. ADDRESS 10901 Winner, Independence, Mo.		22c. DATE SIGNED 10-6-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 8, '59	23c. NAME OF CEMETERY OR CREMATORY Mound Grove		23d. LOCATION (City, town, or county) (State) Independence Missouri			
24. FUNERAL DIRECTOR ADDRESS Roland R. Speaks Independence, Mo				25. DATE RECD. BY LOCAL REG. 10-8-59		26. REGISTRAR'S SIGNATURE <i>James S. Speaks</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 3 1959

DEC 3 1959

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 *Dave J. Smith*

Licensed Embalmer No. 4783

P. O. Address *Judy Smith*

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.