

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

**59-036514**

STATE FILE NUMBER

**FILED VS. NOV 10 1959**

146 Primary Registration District No. 3026 Registrar's No. 497

ENDED

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	a. STATE <b>Mo</b>	b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>	Length of stay in 1b <b>3 Days</b>	c. CITY OR TOWN <b>Blue Springs</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence San &amp; Hosp</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Lake Tapawingo 200A</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)	First <b>Anne</b>	Middle <b>Redheffer</b>	Last <b>Hurd</b>	<b>4. DATE OF DEATH</b>	Month <b>Nov-</b>	Day <b>1-</b>	Year <b>1959</b>
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<b>5. SEX</b> <b>FM</b>	<b>6. COLOR OR RACE</b> <b>Wh</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct 11 1872</b>	<b>9. AGE (last birthday)</b> <b>87</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HR</b>
				Months	Days	Hours Min.

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Kansas City Mo</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>James Redheffer</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary E Craig</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Deceased</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT</b> <b>Mrs Robert Guyer</b>	<b>Address</b> <b>Blue Springs Mo</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hr</b>
IMMEDIATE CAUSE (a)	<b>Cardiac failure</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Generalized arterial sclerosis</b>	
DUE TO (b)		<b>10 yr</b>
DUE TO (c)		

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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<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.)
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<b>20c. TIME OF INJURY</b> Hour a.m. p.m.	Month, Day, Year
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>
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**21. I attended the deceased from** 8-11-57 **to** 11-1-59 **and last saw her** 10-31-59 **alive on**  
**Death occurred at** 12:50 AM **on the date stated above, and to the best of my knowledge, from the causes stated.**

<b>22a. SIGNATURE</b> <i>Merrill R. Bay M.D.</i>	(Degree or title)	<b>22b. ADDRESS</b> <i>Blue Springs, Mo</i>	<b>22c. DATE SIGNED</b> <i>10/2/59</i>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>Nov 3 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Maple Park Cem</b>	<b>23d. LOCATION</b> (City, town, or county) <b>Springfield Mo</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Webb F</b>	<b>ADDRESS</b> <b>Home Blue Springs Mo</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11-3-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>James Craig</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed William Freer

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.