

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6027

MAILED

| | | | | | | | | | |
|---|--|---|--|--|---|--|---|----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. 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>9 years</u> | | c. CITY OR TOWN <u>Kansas City MO.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4106 Warwick Blvd.</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>4106 Warwick Blvd.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Ella</u> Last <u>Hardin</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>13</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 10, 1874</u> | | | |
| 9. AGE (last birthday) <u>85</u> | | 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) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) <u>Boone County, MO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | |
| 13a. FATHER'S NAME <u>Archibald Turner</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Tucker</u> | | | 13c. NAME OF HUSBAND OR WIFE <u>Marion Hardin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mr. R. C. Hardin</u> Address <u>4106 Warwick Blvd</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> | | | | | | | <u>Two Hours</u> | | |
| DUE TO (b) <u>Unknown</u> | | | | | | | | | |
| DUE TO (c) <u>Unknown</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Hypostatic Congestion</u> | | | | | | | 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 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 <u>April 8, 1941</u> to <u>Dec. 13, 1959</u> and last saw her <u>alive</u> on <u>Dec. 8, 1959</u> . Death occurred at <u>2:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Harold A. Pallett, M.D.</u> | | | | 22b. ADDRESS <u>1132 Prof. Bldg. K.C. Mo.</u> | | | | 22c. DATE SIGNED <u>12/14/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>12/16/1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Columbia Missouri</u> (State) | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomers Sons 1331 Brush Creek Blvd. Kansas City Missouri</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>12-15-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u> | | | |

DOCUMENT

Harold A. Pallett 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Chester K Brown

Licensed Embalmer No. 4931

P. O. Address K E M

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.