

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 24 1960

=60-019442

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2603 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>3 yrs.</b>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Paseo N. H. 3433 Paseo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1942 Sterling</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>RUTH</b> Last <b>HOSTER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8th</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/1/1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during mpt. of working life, even if retired) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mt. Sterling, Ky.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Alfred Roberts</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Donaldson</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. Keith Hoster</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Ruth Markham, 1942 Sterling</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>		<b>10 years</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"/> N. <input type="checkbox"/> Unknown	
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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 <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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 **7-1-60** to **5-8-60** and last saw her/him alive on **5-8-60**  
Death occurred at **11:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE (Degree or title) <b>Frank Paul Lacey M.D.</b>		22b. ADDRESS <b>728 S. White Ave</b>	22c. DATE SIGNED <b>5-8-60</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/11/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-11-60</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*D. L. Lammiman*

*BEI-3319*

*Leave at Emergency Room  
Between 11 + 3:00 (A.M.)*

**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 *Robert G. Landes*, Student Embalmer No. *592*

working under my personal supervision

Student *Robert G. Landes* Signed *Joe B. Yoder*  
Signature of Student Embalmer

Licensed Embalmer No. *4173*

P. O. Address *K. C. >*

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.