

Dept. Health,
c. & Welfare
S. Public
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FILED VS JUL 26 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-026716

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 3576

V. S. 300
ev. 1-57

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|---|--|--|--|---|--|--|---|--|---|--|-------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Kansas City</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>St. Joseph Hospital</u> | | | Length of stay in lb <u>4 wks</u> | | d. STREET ADDRESS <u>507 Farley</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>-</u> Last <u>Bearden</u> | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>1960</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 24-1908</u> | | 9. AGE (In years last birthday) <u>5-1</u> | | IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> | | IF UNDER 24 HRS Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Plumber</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Local no. 8</u> | | 11. BIRTHPLACE (City and state or country) <u>Olney, Texas</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13a. FATHER'S NAME <u>Lee Bearden</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Hattie Bartholomew</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Louise Bearden</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u> | | | | 16. SOCIAL SECURITY NO. <u>486-05-2888</u> | | 17. INFORMANT Address <u>Ms. Louise Bearden 507 Farley K.C. Mo.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ | | | | | | | | | | 4201 | | | |
| DUE TO (c) _____ | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> 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. | | | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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>June 15, 1935</u> to <u>July 8, 1960</u> and last saw him alive on <u>July 7, 1960</u> Death occurred at <u>7:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Martin J. Hunter M.D.</u> | | | | | | 22b. ADDRESS <u>1408 Woodhewer Bldg</u> | | | 22c. DATE SIGNED <u>July 5, 1960</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>7-11-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u> | | | 23d. LOCATION (City, town, or county) (State) <u>K.C., Mo</u> | | | | | | |
| 24. FUNERAL DIRECTOR <u>C.H. Blackburn & Son</u> | | | | ADDRESS <u>2 mo. K.C. Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-11-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | | | | | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MARTIN J. HUNTER - MEDICAL CERTIFICATION

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 *W.C. Reine*

Licensed Embalmer No. *4879*

P. O. Address *K.E. Mo*

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: