

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045959

FILED VS DEC 30 1960 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 6259 STATE FILE NUMBER

IDED

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>Johnson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		Length of stay in 1b <u>1 WEEK</u>		c. CITY OR TOWN <u>Holden, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>St. Charles St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Cantrell</u> Last <u>Cantrell</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Female</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>4-16-97</u>	9. AGE (last birthday) <u>63</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>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>MT. VERNON, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>MARTIN L. GARDNER</u>			13b. MOTHER'S MAIDEN NAME <u>HELEN</u>			14. NAME OF HUSBAND OR WIFE <u>J. T. CANTRELL</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>J. T. CANTRELL - HOLDEN, MO.</u> Address _____				
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>thrombosis of middle cerebral artery arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
DUE TO (b) _____									
DUE TO (c) <u>Diabetes mellitus</u>									
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 <u>12/4/60</u> to <u>12/12/60</u> and last saw her <u>alive</u> on <u>12/12/60</u> Death occurred at <u>12/13/60 4:15 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Dr. M. Sperry MD</u> (Degree or title)				22b. ADDRESS <u>409 E 63RD STR. K.C.MO.</u>			22c. DATE SIGNED <u>12/13/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-15-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLDEN CEMETERY</u>			23d. LOCATION (City, town, or county) (State) <u>HOLDEN, MO.</u>				
24. FUNERAL DIRECTOR <u>E.B. CAST</u>			ADDRESS <u>HOLDEN, MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-13-60</u>		26. REGISTRAR'S SIGNATURE <u>H.L. Dwyer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Dr. M. Sperry

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed EB Past

Licensed Embalmer No. 4057

P. O. Address Hollis, N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.