

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-013968

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1928

FILED MAY 8 1961

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 5 weeks		c. CITY OR TOWN Marshall		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marjorie Middle Haas Last Sappington				4. DATE OF DEATH Month April Day 18 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9-2-1889	
9. AGE (last birthday) 72		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) Retired School Teacher				10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (City and state or country) Boonville, Missouri	
12. CITIZEN OF WHAT COUNTRY USA							
13a. FATHER'S NAME William D. Haas				13b. MOTHER'S MAIDEN NAME Ethel Willis		14. NAME OF HUSBAND OR WIFE Wm. Sappington 3510 Anderson K.C.Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Wm. Sappington 3510 Anderson K.C.Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nutritional anemia							INTERVAL BETWEEN ONSET AND DEATH 8 mo
DUE TO (b) malabsorption syndrome							8 mo
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) massive Pulmonary embolus							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 March 13, 1961 to April 18, 61 and last saw her/him alive on April 18, 1961 Death occurred at 12:45 p on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Robert L. Ward, M.D.				22b. ADDRESS 4126 St John		22c. DATE SIGNED 4-19-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE April 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Slater Cemetery		23d. LOCATION (City, town, or county) Slater, Missouri	
24. FUNERAL DIRECTOR Geo. C. Carson & Sons Independence, Mo.				25. DATE RECD. BY LOCAL REG. 4-19-61		26. REGISTRAR'S SIGNATURE Ruth Long	

BY AFFIDAVIT OF **Robert L. Ward**

1922

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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Ms.

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.