

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23157

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 19 1948

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2857

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months
(Specify whether years, months or days)

In this community 4 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 41

(c) City or town Trenton
(If outside city or town limits, write "RURAL") 2

(d) Street No. _____
(If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Myrtle Sheldon

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Samuel

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 11, 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>0</u>	<u>29</u>	<u>hr. min.</u>

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name William J. Gant

13. Birthplace North Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ann Mc Gaugh

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Velma S. Knight

(b) Address Cedar Rapids, Iowa

17. (a) Removal (b) Date thereof 7-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trenton, Missouri

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) 7-10-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Failure - 1 hr

Due to Coronary Sclerosis (4 yrs.)

Due to Fascial Sarcoma

Other conditions Right Thigh (1 yr)
(Include pregnancy within 3 months of death)

Major findings: Of operations 552

Of autopsy See Above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, or in an industrial place, or public place?
(Specify type of place) (Specify means of injury)

While at work (See Pathologist)

23. Signature A. E. Usher (M. D. or other) MD

Address 2800 Main Date 7/10/48

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER

JAN 19 1950

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Willie H. Bennett

Licensed Embalmer No.

4438

P. O. Address

K. C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.