S. No. 300
v. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1159

State File No.

BIRTH NO. 49-001746 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 290

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Willows

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 2929 MMain St.

3. NAME OF DECEASED (Type or Print)
a. (First): Nola
b. (Middle):
c. (Last): Ash

4. DATE OF DEATH (Month) Jan. (Day) 15 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Wh.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: Jan. 13, 1949
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days 2; IF UNDER 1 DAY Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME:
13b. MOTHER'S MAIDEN NAME: Anna May Ash
14. NAME OF HUSBAND OR WIFE: Infant
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Infant (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Alice U. Dysart, RN. **ADDRESS:** 2929 Main, K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congenital Heart — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

754.11

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 13, *1949, to* Jan. 15, *1949, that I last saw the deceased alive on* Jan. 15, *1949, and that death occurred at* 5:45a. *m., from the causes and on the date stated above.*

23a. SIGNATURE: H. L. Dwyer (Degree or title) M.D.
23b. ADDRESS: 315 Alameda Rd.
23c. DATE SIGNED: Jan. 15, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-21-49
24c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Kansas City, Missouri

DATE REC'D BY LOCAL REG.: 1-21-49
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: WILKS FUNERAL HOME 2315 Linw od K.C.Mo

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside city limits, write RURAL and give township) OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION
e. STREET ADDRESS (If rural, give location)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE
b. COUNTY
c. CITY (If outside city limits, write RURAL) OR TOWN

3. NAME OF DECEASED (Type or Print)
a. (First)
b. (Middle)
c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)
5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (Last birthday) Years
If under 1 year: Months Days
If under 1 day: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME
ADDRESS

18. CAUSE OF DEATH
Enter only one cause on line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication that caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the immediate cause (a) stating the underlying cause last. DUE TO (b) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing it. Not

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION

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 _____ working under my personal supervision.

Student Embalmer No. _____

20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (In or about home, farm, factory, office, public place)
21c. (CITY, TOWN, OR TOWNSHIP)
21d. TIME OF INJURY
21e. HOW DID INJURY OCCUR?

Signed Chas E Wields
Licensed Embalmer No. 2644
P. O. Address Kansas City Mo

Signed _____
Student Embalmer

22. SIGNATURE
23. ADDRESS (Degree or title)
24. DATE SIGNED

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

25a. BURIAL, CREMATION, REMOVAL (Specify)
25b. DATE
25c. NAME OF CEMETERY OR CREMATORY

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
26. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

WARNING: IT IS A FELONY TO ALTER OR DEFACE THIS CERTIFICATE

DECEDENT'S RESIDENCE