

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30645
3638

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
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>JACKSON</u> <u>48</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>25</u> years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u> <u>50</u>		<u>30</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3537 Main</u>				d. STREET ADDRESS (If rural, give location) <u>3537 Main</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MINNIE</u>		b. (Middle) <u>A.</u>		c. (Last) <u>WAYDELICH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 21, 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Dec. 30, 1870</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u> <u>D</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>JOHN H. THORP</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA BOTTS</u>		14. NAME OF HUSBAND OR WIFE <u>J. SHERIDAN WAYDELICH</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>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ELGIN J. WAYDELICH, 4011 Olive</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 days,</u> <u>4 mos.</u> <u>Several years.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1949</u> , to <u>Aug 20, 1949</u> , that I last saw the deceased alive on <u>Aug 20, 1949</u> , and that death occurred at <u>4:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE OF JOHN M. POWERS (Degree or title) <u>John M. Powers M.D.</u>				23b. ADDRESS <u>3304 Linwood</u>		23c. DATE SIGNED <u>8/22/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>8/23/49</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>CHILLICOTHE, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>8-23-49</u>		REGISTRAR'S SIGNATURE <u>Heraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Quirk & Sobin 20 W. Linwood</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Mr. John M. Powers
336 1/2 Lincoln
1-5

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
Student Embalmer

Signed Maudie Adair

Licensed Embalmer No. 4016

P. O. Address 20 W. Lincoln

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.