

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 20 1950

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 778

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 72 yrs		d. STREET ADDRESS (If rural, give location) 8100 WORNALL	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8100 WORNALL ROAD			

2938

3. NAME OF DECEASED (Type or Print) a. (First) Sallie b. (Middle) Platt c. (Last) Dedman			4. DATE OF DEATH (Month) (Day) (Year) FEB. 18 1950		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH JULY 16, 1861		9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED*HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME SAMUEL J. PLATT		13b. MOTHER'S MAIDEN NAME EMILY MILLER		14. NAME OF HUSBAND OR WIFE UNKNOWN	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. ELIZABETH SCHRIEBER 8100 WORNALL	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: 4-21			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Dec 1936, to Feb 19 1950, that I last saw the deceased alive on Feb 14 1950, and that death occurred at 11 4 m., from the causes and on the date stated above.

23a. SIGNATURE C. D. Cantrell (Degree or title) D. M. D.		23b. ADDRESS 636 Argyle St.		23c. DATE SIGNED Feb 20-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 2/20/50		24c. NAME OF CEMETERY OR CREMATORY FOREST HILL		24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI	
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DATE REC'D BY LOCAL REG. 2-20-50		REGISTRAR'S SIGNATURE Heraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & MC CLURE KANSAS CITY, MO.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Joseph M. McCarthy
Mar 01 1949*

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..... *Joseph M. McCarthy*

Licensed Embalmer No. *46942*

P. O. Address: *KC Mo*

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.