

FILED AUG 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23248

State File No.

3142

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City	c. LENGTH OF STAY (in this place) 18 days	c. CITY (If outside corporate limits, write RURAL and give township) Overland Park	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran		d. STREET ADDRESS (If rural, give location) 7603 Metcalf	

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) WESTON c. (Last) STORR			4. DATE OF DEATH (Month) (Day) (Year) 7 20 1951		
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 11, 1867		9. AGE (to years last birthday) 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas Weston		13b. MOTHER'S MAIDEN NAME Mary McDonald		14. NAME OF HUSBAND OR WIFE Rainer Storr	
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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. Mabel Fenner, K.C.Mo.			
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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) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bladder tumor 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 2 wks.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Bladder Tumor malignant		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?	
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22. I hereby certify that I attended the deceased from July 1951, to 20 July 1951, that I last saw the deceased alive on her July 5 and that death occurred at 4 P. m., from the causes and on the date stated above.

23a. SIGNATURE H. C. Carlson M.D.		23b. ADDRESS 1316 Professional Bldg	23c. DATE SIGNED 23 July 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 23, 1951	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	24d. LOCATION (City, town, or county) (State) Jackson, Missouri	
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DATE REC'D BY LOCAL REG. 7-23-51	REGISTRAR'S SIGNATURE Rosalind Palmer	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FREEMAN MORTUARY & CHAPEL, K.C., MO.		
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address: Kansas City, 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.