

FILED AUG 4 1952

STANDARD CERTIFICATE OF DEATH

24418
State File No. 3236

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3236

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) 50 YEARS		d. STREET ADDRESS (If rural, give location) 1617 Elmwood 323,8	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			

3. NAME OF DECEASED (Type or Print) a. (First) Elvin b. (Middle) THOMAS c. (Last) Douglass		4. DATE OF DEATH (Month) (Day) (Year) 7 15 52	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCTOBER 19, 1867
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOCTOR		10b. KIND OF BUSINESS OR INDUSTRY DENTISTRY	11. BIRTHPLACE (State or foreign country) BOONVILLE, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME JAMES DOUGLASS	13b. MOTHER'S MAIDEN NAME RILLA FRYER	14. NAME OF HUSBAND OR WIFE MYRTLE DOUGLASS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Miss Lois Douglass ADDRESS 1617 Elmwood 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 33 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 10, 1952 to July 15, 1952, that I last saw the deceased alive on July 15, 1952, and that death occurred at 9:15P m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns, M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 7-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE July 17, 1952	24c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 7-17-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE D. H. Newcomer's Sons, Kansas City, Mo. ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Remondin

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

John R. Sidman

Licensed Embalmer No. *4531*

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.