

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28341

State File No.

3688

FILED AUG 30 1952

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

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

1. PLACE OF DEATH a. COUNTY Jackson <i>0</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson <i>30 48</i>	
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 <i>0</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Northeast Hosp.		d. STREET ADDRESS (If rural, give location) 746 No. Garland Ave. <i>4</i>	
3. NAME OF DECEASED a. (First) Mary		b. (Middle) Ellen	
c. (Last) Vassar		4. DATE OF DEATH (Month) (Day) (Year) 8 17 52	
5. SEX Female <i>1</i>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow <i>2</i>	8. DATE OF BIRTH Jan. 5th, 1875
9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 7 Days 17	IF UNDER 28 HRS. Hours 17 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Missouri <i>d</i>		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Henry Hontz		13b. MOTHER'S MAIDEN NAME Ellena Vassar	
14. NAME OF HUSBAND OR WIFE Samuel O Vassar		K. C. Mo	
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 John H. Vassar		ADDRESS 2619 Campbell	
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis	
		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
		33 1/2	
		5 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min.)		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 11-28, 1949 , to Aug. 17, 1952 , that I last saw the deceased alive on Aug. 17, 1952 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Glenn W. Springer (Degree or title) Glenn W. Springer, D.O.		23b. ADDRESS 5902 St. John Ave. Kansas City, Mo.	
23c. DATE SIGNED 8-17-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/19/52	
24c. NAME OF CEMETERY OR CREMATORY Mound Grove Cem.		24d. LOCATION (City, town, or county) (State) Ind. Mo.	
DATE REC'D BY LOCAL REG. 8-18-52		REGISTRAR'S SIGNATURE Sheraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE Earp & Sons		ADDRESS Kansas City Mo.	

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.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *John R. Camp*
Licensed Embalmer No. *29550*
P. O. Address *J.C. Reed*

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.