

FILED MAR 19 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9836**
1200

BIRTH NO. _____ 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		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) 1947		d. STREET ADDRESS (If rural, give location) 3516 Summit Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3516 Summit Street Crest Haven Convalescent Home			

3. NAME OF DECEASED (Type or Print) MINNIE	a. (First) M	b. (Middle) FRANCE	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb. 25, 1953
---	---------------------	---------------------------	-----------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 9, 1868	9. AGE (In years) (Month) (Day) (Year) 84	IF UNDER 1 YEAR Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	--------------------------------------	--	----------------------------	-----------------------------

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 (City and State or Foreign Country) Springfield, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	--	---	--

13a. FATHER'S NAME Thos Wichersham	13b. MOTHER'S MAIDEN NAME Katherine Rausch	14. NAME OF HUSBAND OR WIFE Lake France, Deceased
---	---	--

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 Mr. Harold France	ADDRESS 20 Client Rd. Great Neck Long Island, New York
---	-------------------------------------	--	---

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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arterio sclerosis		3 yrs
	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.			354 1/2

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)	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 Sept 5, 1948, to Feb 25, 1953, that I last saw the deceased alive on Feb 16, 1953, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE Martin J. Mueller MD	(Degree or title)	23b. ADDRESS m: D.O. 934 Angier Bldg KC Mo.	23c. DATE SIGNED 2-26-53
--	-------------------	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	24b. DATE Feb. 26, 1953	24c. NAME OF CEMETERY OR CREMATORY D. W. NEWCOMER'S SONS	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	--------------------------------	---	--

DATE REC'D BY LOCAL REG. 2-27-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE D.W. Newcomer's Sons	ADDRESS 1331 BRUSH CORN KANSAS CITY, MO.
---	--	--	---

(Licensed Embalmer's Statement on Reverse Side)

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 Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Hanson City, MA

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.