

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1204

State File No. _____

BIRTH NO. FILED FEB 4 1954 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 183

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City 43</u>		c. LENGTH OF STAY (in this place) <u>43 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K.C. Tuberculosis Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>502 Cass 315-80</u>			
3. NAME OF DECEASED a. (First) <u>Harry Franklin Axton</u> b. (Middle) _____ c. (Last) _____ (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year) <u>1-12-1954</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH <u>4-5-1900</u>	
9. AGE (In years last birthday) <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Carrollton Missouri</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>H. H. Axton</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Jew</u>			14. NAME OF HUSBAND OR WIFE <u>Josephine Axton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>496-8307</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Josephine Axton 502 Cass K.C. Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>496-03-8307</u>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				INTERVAL BETWEEN ONSET AND DEATH			
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.				002			
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 <u>1-8-1954</u> , to <u>1-12-1954</u> , that I last saw the deceased alive on <u>1-12-1954</u> , and that death occurred at <u>12:50 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Edward P. Altomare M.D.</u> (Degree or title)				23b. ADDRESS <u>K.C. I.B. Hospital</u>		23c. DATE SIGNED <u>1-12-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 15-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-13-54</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs. C.L. Forster Kansas City Mo.</u>			

(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.....
Signature of Student Embalmer

Signed.....

Dean Owens

Licensed Embalmer No. *42*

P. O. Address *K. C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.