

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 28 1954

State File No. **12230**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1592

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. LENGTH OF STAY (in this place) 40 yrs	c. CITY OR TOWN Kansas City	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 Kansas City Tuberculosis		e. STREET ADDRESS (If rural, give location) 29 1509 Penn 2298	

3. NAME OF DECEASED (Type or Print) a. (First) Viola	b. (Middle)	c. (Last) Sloan	4. DATE OF DEATH (Month) (Day) (Year) April 7 1954
----------------------------------------------------------------	-------------	------------------------	--------------------------------------------------------------

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 10, 1905	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
----------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	------------------------	------------------------	----------------------

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 (City and State or Foreign Country) Colorado Springs, Colorado	12. CITIZEN OF WHAT COUNTRY? U.S.
-----------------------------------------------------------------------------------------------------------------	--------------------------------------------------	--------------------------------------------------------------------------------------	------------------------------------------

13a. FATHER'S NAME Thomas J. Hodkinson	13b. MOTHER'S MAIDEN NAME Mamie Kemp	14. NAME OF HUSBAND OR WIFE J. B. Sloan
-----------------------------------------------	---------------------------------------------	------------------------------------------------

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. 522-26-9790	17. INFORMANT'S SIGNATURE OR NAME J. B. Sloan ADDRESS 1509 Penn
-----------------------------------------------------------------------------------------------------------------------	--------------------------------------------	-------------------------------------------------------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	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 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 4-1-, 1954, to 4-7-, 1954, that I last saw the deceased alive on 4-7-, 1954, and that death occurred at 4:10A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edward P. Altman M.D.	23b. ADDRESS K.C. T. B. Hospital	23c. DATE SIGNED 4-7-54
---------------------------------------------------------------	-----------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-9-54	24c. NAME OF CEMETERY OR CREMATORY Maple Hill	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
---------------------------------------------------------	-------------------------	------------------------------------------------------	--------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 4-8-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE B. E. Weilert ADDRESS Kansas City 8, Mo.
----------------------------------------	----------------------------------------------	-----------------------------------------------------------------------------------------

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..... *B. E. Weiler*

Licensed Embalmer No. *40*

P. O. Address *K.C. 81*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.