

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30821**  
**4349**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>KANSAS</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>MISSION</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>3 days</b>		e. STREET ADDRESS (If rural, give location) <b>5801 Reeds Road</b> <b>815<sup>0</sup>8</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MENORAH HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Grace</b>		b. (Middle) <b>D.</b>		c. (Last) <b>Seutter</b>		4. DATE OF DEATH (Month) <b>9</b> (Day) <b>10</b> (Year) <b>1954</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>3-9-1902</b>		9. AGE (In years last birthday) <b>52</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 M. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Tulsa Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	

13a. FATHER'S NAME <b>Clarence Hobson</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Gus N. Seutter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mr. Gus N. Seutter Mission, Kan.</b>	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion, old, extensive infarct</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>451x</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>1. hypertensive Coronary arteriosclerosis</b>		
	DUE TO (c) <b>Thrombotic abdominal Arterioarteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocardial infarct Pulmonary valve</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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 12/9, 1954, to 9/10, 1954, that I last saw the deceased alive on 9/9, 1954, and that death occurred at 8 P m., from the causes and on the date stated above.

23a. SIGNATURE <b>G.R. Maser MD</b> (Degree or title)		23b. ADDRESS <b>Mission, Kansas</b>		23c. DATE SIGNED <b>9/11/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-13-1954</b>		24c. NAME OF CEMETERY OR CREMATOR <b>Johnson Co. Memorial</b>	
24d. LOCATION (City, town, or county) (State) <b>Overland Park, Kansas</b>					

DATE REC'D BY LOCAL REG. <b>9-11-54</b>		REGISTRAR'S SIGNATURE <b>neva minshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. Paul Amos Funeral Home, Shawnee Kan.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Handwritten scribble*

**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.....  
*Edna Jones*

Licensed Embalmer No. *438*

P. O. Address *Shawnee, K.*

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.