

FILED DEC 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

37299

5193

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>5193</u>	
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</u>		c. LENGTH OF STAY (in this place) <u>15 yrs.</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTHEAST HOSPITAL (DOA)</u>				STREET ADDRESS (If rural, give location) <u>2811 E 12th ST 3248</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>RHODA</u>		b. (Middle) <u>MAE</u>		c. (Last) <u>CAIVERT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 5 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>MAY 20, 1904</u>	
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Doctors Office</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Richards Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Charles Calvin Norris</u>		13b. MOTHER'S MAIDEN NAME <u>MYRTLE MARTIN</u>		14. NAME OF HUSBAND OR WIFE <u>Oliver R. Caivert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>49-05-8857</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>OLIVER R. CAIVERT 2811 E 12th ST.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute myocardial failure</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypostatic pneumonia</u> DUE TO (c) <u>Hemorrhagic disthesis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophy of the Pituitary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u> <u>2.96 h</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		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) (Minute) <u>no</u>		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>10/29, 1954</u> , to <u>11/5, 1954</u> , that I last saw the deceased alive on <u>11/5, 1954</u> , and that death occurred at <u>2:00 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. O. Pence</u>				23b. ADDRESS <u>Do. 2 2722 Prospect</u>		23c. DATE SIGNED <u>11/6/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Nov 7, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>—</u>		24d. LOCATION (City, town, or county) (State) <u>FORT SCOTT KANSAS</u>	
DATE REC'D BY LOCAL REG. <u>11-6-54</u>		REGISTRAR'S SIGNATURE <u>neva minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sheil FUNERAL Home J.C. Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

3732 Project

5/12-88

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 *Thomas A. Sheel*

Licensed Embalmer No. *493*

P. O. Address *X.C. 7*

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.