

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33069

State File No. ....

FILED OCT 25 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4250

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) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>LEE'S SUMMIT</u>	
c. LENGTH OF STAY (in this place) <u>1 week</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>Research Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>1001</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MABEL</u>	b. (Middle) <u>B</u>	c. (Last) <u>AUSTIN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 1, 1955</u>
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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>DEC. 14, 1893</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>SHERIDAN, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>FRANK BURSACK</u>	13b. MOTHER'S MAIDEN NAME <u>MARY BERNARD</u>	14. NAME OF HUSBAND OR WIFE <u>JACK L. Austin</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>JACK L. AUSTIN</u>	ADDRESS <u>LEE'S Summit, Missouri</u>
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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, ashenia, 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) <u>Cardiac tamponade</u>		<u>30 min</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Rupture left ventricle</u> DUE TO (c) <u>myocardial infarction</u>		<u>30 min</u> <u>14 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4201</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9 Sept, 1955 to 1 Oct, 1955, that I last saw the deceased alive on 1 Oct, 1955, and that death occurred at 7:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Jack M. Davis, M.D.</u> (Degree or title)	23b. ADDRESS <u>Raytown, Mo.</u>	23c. DATE SIGNED <u>3 Oct 55</u>
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24a. BURIAL CREMATION (Specify) <u>BURIAL</u>	24b. DATE <u>OCTOBER 5, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL MEMORIAL GARDENS</u>	24d. LOCATION (City, town, or county) (State) <u>WICHITA KANSAS</u>
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DATE REC'D BY LOCAL REG. <u>10-4-55</u>	REGISTRAR'S SIGNATURE <u>Troy Minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. Newcomer's Sons</u>	ADDRESS <u>1301-Burns Creek KANSAS CITY, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Richard L. Rogers*.....

Licensed Embalmer No. *44*.....

P. O. Address *H.C.*.....

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.