

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33580**
Registrar's No. **4623**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City
c. LENGTH OF STAY (In this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
a. STATE Missouri b. COUNTY Bates
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Butler Missouri
d. STREET ADDRESS (If rural, give location) 0071

3. NAME OF DECEASED
a. (First) HATTIE b. (Middle) THEDFORD c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)
Oct. 27 1955

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, ³WIDOWED, DIVORCED (Specify)
Widow divorced

8. DATE OF BIRTH 12/25/1879

9. AGE (In years last birthday) 76 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)
At home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
Missouri

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
William Perry

13b. MOTHER'S MAIDEN NAME
Mary

14. NAME OF HUSBAND OR WIFE
unknown

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.
none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Clyde Turner Butler Missouri

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) Cerebral Thrombosis
ANTECEDENT CAUSES DUE TO (b) arteriosclerosis
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS.
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Atelectasis

INTERVAL BETWEEN ONSET AND DEATH
< 1 wk
Not known
332 X
1 wk

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 1955, to 10-27, 1955, that I last saw the deceased alive on 10-27, 1955, and that death occurred at 10:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE John N. Cashman (Degree or title)
John N. Cashman, MD.

23b. ADDRESS Argyle Bldg. Kansas City, Mo.
23c. DATE SIGNED 10-27-55

24a. BURIAL/CREMATION, REMOVAL (Specify)
removal

24b. DATE 10/27/55

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)
Butler Mo

DATE RECD BY LOCAL REG. 10-27-55 REGISTRAR'S SIGNATURE Neve Marshall

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Stine & McClure Kansas City, Mo

DEC 9 1955

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

Student Embalmer

Signed

Eugene Henson

Licensed Embalmer No. 4633

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.