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FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36751

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4859

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>KANSAS CITY</u>	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) <u>5 MONTHS</u>		e. STREET ADDRESS (If rural, give location) <u>5415 <del>54th</del> FOREST AVENUE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5415 FOREST AVENUE</u>		3758 0	

3. NAME OF DECEASED (Type or Print) a. (First) <u>BERTHA</u> b. (Middle) <u>BOURNE</u> c. (Last) <u>BOURNE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. - 9 - 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>July 2, 1877</u>
9. AGE (In years last birthday) <u>78</u>	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>WARFIELD, IOWA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JAMES H. BALDRIDGE</u>	
13b. MOTHER'S MAIDEN NAME <u>EMMA F. BATES</u>		14. NAME OF HUSBAND OR WIFE <u>HARRY H. BOURNE</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs BERNICE B. WALTON R. MD.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Disruptive aneurysm of Circle of Willis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH  <u>330h</u>
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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) (Min.)	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 5:00p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Geo. C. Kealhofer</u> (Degree or title) <u>3</u>		23b. ADDRESS <u>6627 Reservoir Dr. Over</u>	23c. DATE SIGNED <u>11-10-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>NOV. 11 - 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>SALT LAKE CITY UTAH</u>
DATE REC'D BY LOCAL REG. <u>11-11-55</u>	REGISTRAR'S SIGNATURE <u>Werner Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>1537 1/2 Main Street</u>	

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 *Edward M. Stone*.....

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

P. O. Address *K.C. 110*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E) 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.