

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

469

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 55 yrs.	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION 5621 E. 35th St. Terr.		STREET ADDRESS (If rural, give location) 5621 E. 35th St. Terr.	
3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) Calvin c. (Last) Clay		4. DATE OF DEATH (Month) (Day) (Year) Jan. 27, 1956	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 2, 1888
9. AGE (In years last birthday) 67		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) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber shop	11. BIRTHPLACE (City and State or Foreign Country) (unknown) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Jiles Clay	
13b. MOTHER'S MAIDEN NAME Hattie (unknown)		14. NAME OF HUSBAND OR WIFE Oma Clay	
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. _____	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Oma Clay		ADDRESS 5621 E. 35th St. Terr.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 day ANTECEDENT CAUSES DUE TO (b) Arterio Sclerosis 5 years DUE TO (c) Nephritis 5 years II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		446X	
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 Dec. 1, 1953 , to Jan 27, 1956 , that I last saw the deceased alive on Jan. 26, 1956 and that death occurred at 5:10 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Carl T. Moore (Degree or title)		23b. ADDRESS 6425 E-37 & K.C. 29, Mo	
23c. DATE SIGNED 2-1-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/1/56	
24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
DATE REC'D BY LOCAL REG. 2-1-56		REGISTRAR'S SIGNATURE Neva Marshall	
25. FUNERAL DIRECTOR'S SIGNATURE Badeau, Appleton & Jones, Inc., K. C. Mo.		ADDRESS	

FILED FEB 17 1956

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 *Consuelo Gladys Bala*.....

Licensed Embalmer No. *494*

P. O. Address *K.C., Mo.*

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.