

FILED APR 11 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9017

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1255

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u> |  | c. LENGTH OF STAY (in this place) (township) <u>40yrs</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>650I E 10th St.</u>                      |  | e. STREET ADDRESS (If rural, give location) <u>650I E 10th St.</u>  |  |

|                                     |                       |                           |                          |   |
|-------------------------------------|-----------------------|---------------------------|--------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Ora</u> | b. (Middle) <u>Candis</u> | c. (Last) <u>Calahan</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>March 19, 1956</u> |
|-------------------------------------|-----------------------|---------------------------|--------------------------|---|

|                      |                               |  |                                       |   |   |  |
|----------------------|-------------------------------|--|---------------------------------------|---|---|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>Aug. 19, 1889</u> | 9. AGE (In years last birthday) <u>66</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 4 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|--|---------------------------------------|---|---|--|

|  |   |   |  |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and State or Foreign Country) <u>Lathrop Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|---|---|--|

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|--|---|--|
| 13a. FATHER'S NAME <u>Robert Trotter</u> | 13b. MOTHER'S MAIDEN NAME <u>Parvin</u> | 14. NAME OF HUSBAND OR WIFE <u>unknown</u> |
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|--|--|---|
| 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>494-14-5204</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert T Calahan 3444 Campbell K.C.Mo.</u> |
|--|--|---|

|  |   |                  |                                  |
|--|---|------------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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>Coronary Thrombosis</u>   |                  | <u>1 hour</u>                    |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br>DUE TO (c) <u>Malignant hypertension</u> |                  | <u>4 1/2</u><br><u>8-10 yrs.</u> |
| II. OTHER SIGNIFICANT CONDITIONS<br>*Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic heart disease with coronary sclerosis</u>                             |   | <u>8-10 yrs.</u> |                                  |

|                              |  |   |
|------------------------------|--|---|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input 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) _____ | 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 June 21, 1950, to Mar. 19, 1956 that I last saw the deceased alive on 4-25-55, 1955, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

|  |   |                                 |
|--|---|---------------------------------|
| 23a. SIGNATURE <u>Morris Morris Duncan</u> (Degree or title) _____ | 23b. ADDRESS <u>Kansas City, Missouri</u> | 23c. DATE SIGNED <u>3-20-56</u> |
|--|---|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>3-22-56</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Plattsburg</u> | 24d. LOCATION (City, town, or county) (State) <u>Plattsburg Mo.</u> |
|---|--------------------------|--|---|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG. <u>3-22-56</u> | REGISTRAR'S SIGNATURE <u>Neva Minshall</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs. C.L. Forster Funeral Home Kansas City Mo</u> |
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

Dr. Duncan VA I-3610  
Worthman Bldg.

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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.....

Licensed Embalmer No. 3588

P. O. Address J. C. M.

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.