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FILED MAR 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9251
Registrar's No. 1117

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 002

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 township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hosp		e. STREET ADDRESS (If rural, give location) 2017 Summit St.	
3. NAME OF DECEASED (Type or Print) a. (First) Arnulfo b. (Middle) (Last) Ojeda		4. DATE OF DEATH (Month) (Day) (Year) 3-10-56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 12, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY K.C.T.R.R.	11. BIRTHPLACE (City and State or Foreign Country) Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Eva Ojeda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. "Unk"	
17. INFORMANT'S SIGNATURE OR NAME Eva Ojeda		ADDRESS Same	

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) ARTERIOSCLEROSIS OF CEREBRAL ARTERIES (b) INFARCT OF LEFT CEREBRAL CORTEX DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 24 HRS 332X
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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 (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) (Minute)		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 3-9, 1956, to 3-10, 1956, that I last saw the deceased alive on 3-10, 1956, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE J.E. Castles		(Degree or title) M.D.		23b. ADDRESS 1002 Angyle Bldg.		23c. DATE SIGNED 3-12-56	
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		24b. DATE 3-13-56		24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24d. LOCATION (City, town, or county) (State) Kansas City, Kan.	
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DATE REC'D BY LOCAL REG. 3-13-56		REGISTRAR'S SIGNATURE reva minshall		25. FUNERAL DIRECTOR'S SIGNATURE B.C. Wilent: K.C.S.M.		PAGE 55	
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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 emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *B. E. Weiland*

Licensed Embalmer No. *402*

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

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