

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
M.B. Casebolt, M.D.

FILED AUG 29 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27229

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3400

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give hospital or institution) <b>4 2826 CAMPBELL ST.</b>			Length of stay in lb <b>6 YEARS</b>		d. STREET ADDRESS <b>2826 CAMPBELL ST.</b>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle Last <b>WILSON</b>			4. DATE OF DEATH <b>AUGUST 8 - 1956</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC-26-1880</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>TRENTON MISSOURI</b>	
13. FATHER'S NAME <b>JAMES Mc HARGUE</b>			14. MOTHER'S MAIDEN NAME <b>ELIZA WELLS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>JAMES H. WILSON</b> Address <b>1519 EAST 59TH ST. KANSAS CITY MO.</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arterio sclerosis</b>					<b>5 yrs</b>
DUE TO (c) <b>Senility</b>					<b>42-01</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>June 1, 1956</b> to <b>Aug 8, 1956</b> and last saw her alive on <b>Aug 8, 1956</b> Death occurred at <b>8:50 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>M. B. Casebolt M.D.</b>			22b. ADDRESS <b>4000 Baltimore</b>		22c. DATE SIGNED <b>8/19/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG-10-1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MASONIC CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>TRENTON MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER SONS</b>		ADDRESS <b>1331 BRUSH CREEK KANSAS CITY MO.</b>		25. DATE RECD. BY LOCAL REG. <b>8-9-56</b>	26. REGISTRAR'S SIGNATURE <b>Newman</b>

(Licensed Embalmer's Statement on Reverse Side)

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. Ste...* .....

Licensed Embalmer No. *4*

P. O. Address *Kicil*

*029 15710*

*2512 1111*

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.