

#7

Health, Welfare, Public Service

300 7-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. 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.

FILED MAR 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5149

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 94

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>Independence</b>		c. CITY OR TOWN <b>Independence</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence San</b>		d. STREET ADDRESS (If outside, give location) <b>40 Hway &amp; Carl Rd</b>	
Length of stay in lb <b>6 yrs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>MAE</b> Last <b>WARD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1931 March 13 1957-</b>	9. AGE (In years last birthday) <b>25</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Boon County Missouri</b>	
13. FATHER'S NAME <b>B Davis</b>			14. MOTHER'S MAIDEN NAME <b>Velma Calvert</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 Address <b>Samuel Ward 40 Hway &amp; Carl Rd</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>Peritonitis - Generalized -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>About 7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pelvic Inflammatory Disease</b>	?
	DUE TO (c) <b>?</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 checked="" type="checkbox"/> NO <input 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 <b>a. m.</b> Month <b>p. m.</b> Day, Year		
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 3/1/1957 to 3/5/1957 and last saw her alive on 3/7/57  
Death occurred at about 12 noon m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>R. J. [Signature] MD</b>	22b. ADDRESS <b>[Signature] Mo</b>	22c. DATE SIGNED <b>3-6-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 8 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Columbia Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Sheil Funeral Home Kansas City Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>3-7-57</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

(Licensed Embalmer's Statement on Reverse Side)

MAR 11 1957

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 *Thomas A. Sheil* .....

Licensed Embalmer No. 493

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

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