

FILED MAR 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

8856

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1006

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Our Lady Of Mercy HOME</u>			Length of stay in <u>44 yrs.</u>	d. STREET ADDRESS <u>Our Lady Of Mercy HOME</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JANE</u> First <u>MARIE</u> Middle <u>PIERSON</u> Last				4. DATE OF DEATH <u>MARCH 2 1957</u> Month Day Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN-19, 1876</u>		9. AGE (In years last birthday) <u>81</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home - Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OSKALOOSA, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN ROUSE</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
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>NONE</u>		17. INFORMANT <u>MR. HARVEY PIERSON</u>		Address <u>7611 34th St. - Bae. City, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage - hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>sensile change</u>						?	
DUE TO (c)						3 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)						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 <u>2-13-57</u> to <u>3-2-57</u> and last saw her/him alive on <u>3-2-57</u> Death occurred at <u>6:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (In free or title) <u>Wm R. Jackson MD</u>				22b. ADDRESS <u>1107 Bryant Bldg</u>		22c. DATE SIGNED <u>3/4/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR. 5. 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. WASHINGTON CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>			ADDRESS <u>K.C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-4-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Wm. R. Jackson

with, self, public, service, 1000-56, Doctor, coronar, etc. must use only standard nomenclature in report. No symptoms may be stated. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

212-0848

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 *Robert Ray*.....

Licensed Embalmer No. *41*.....

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.