. Health,
& Welfare
. Public
h Service

S. 30
. 1-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13552
STATE FILE NUMBER

FILED APR 19 1957

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 27

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only): ~~Rural Washington~~ TOWN: ~~MARTIN CITY~~ — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 105th WORNALL — Length of stay in 1b: UNK

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: JACKSON
c. CITY OR TOWN: MARTIN CITY — Inside Limits: Yes ☐ No X
d. STREET ADDRESS (If outside, give location): 105TH WORNALL — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: AMOS Last:

4. DATE OF DEATH Month Day Year: 4 - 7 - 1957

5. SEX: MALE **6. COLOR OR RACE**: WHITE **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1904 **9. AGE** (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOR
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): UNK
12. CITIZEN OF WHAT COUNTRY?: UNK

13. FATHER'S NAME: UNK
14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): UNK (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: MRS B. AMOS Address: NORBORNE, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cause of Death unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Part Refused 7955
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hugh A Owens Coroner
22b. ADDRESS: 1034 Baltimore Bldg
22c. DATE SIGNED: 4-9-57

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 4-11-1957
23c. NAME OF CEMETERY OR CREMATORY: Mt. CALVARY CEM.
23d. LOCATION (City, town, or county) (State): KANSAS CITY KANS.

24. FUNERAL DIRECTOR: PASSANTINO BROS **ADDRESS**: KC MO
25. DATE RECD. BY LOCAL REG.: 4-9-57
26. REGISTRAR'S SIGNATURE: Shirley Goddard

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

APR 18 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leonard Passantino

Licensed Embalmer No. 455

P. O. Address KCM

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