

FILED JUN 12 1957

STANDARD CERTIFICATE OF DEATH

173370
STATE REGISTRATION NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2418

S. 300
1-57

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, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6221 E 9th St		Length of stay in lb 35 yrs	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle LOUIS Last SPAULDING		4. DATE OF DEATH Month May Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel	11. BIRTHPLACE (City and state or country) Plainfield Michigan
13a. FATHER'S NAME Elliott Spaulding		13b. MOTHER'S MAIDEN NAME Caroline Rappleyea	14. NAME OF HUSBAND OR WIFE Bessie Viola Spaulding
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 486-01-1120	17. INFORMANT Mrs Bessie Spaulding Address 6221 E 9th St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 4200
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 _____, 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 Hugh H Owens (Degree or title) 3		22b. ADDRESS 1034 Realto Bldg	
22c. DATE SIGNED 5-24-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 27 1957	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town, or County) (State) Independence Missouri
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo ADDRESS _____		25. DATE RECD. BY LOCAL REG. 5-24-57	26. REGISTRAR'S SIGNATURE neva minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Hugh H. Owens



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. Heil*

Licensed Embalmer No. *4954* P. O. Address *X C 110*

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.