

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

157 021289  
STATE FILE NUMBER  
2556

FILED JUN 19 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2556

Health, Welfare, Public Services  
300-56  
diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Merrill D. Athon

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</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>—</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Westport Nursing</b>		Length of stay in lb <b>4 Yrs.</b>		8150 d. STREET ADDRESS <b>3117 W. 69th</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ALMA</b> Middle <b>M.</b> Last <b>QUARFORTH</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1957</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>2-24-1869</b>		9. AGE (In years last birthday) <b>88</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>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Johannas Braun</b>				14. MOTHER'S MAIDEN NAME <b>—</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>Mrs. A. E. Carlson 3117 W. 69th</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>Pneumonia Bronchial</b> DUE TO (b) <b>Senility</b> DUE TO (c) <b>C.V.A.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n).						INTERVAL BETWEEN ONSET AND DEATH <b>331 1/2</b>		
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								
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>March 20, 57</b> to <b>now</b> and last saw <sup>her</sup> <del>him</del> alive on <b>May 25, 57</b> Death occurred at <b>2:30</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Merrill D. Athon M.D.</b>				22b. ADDRESS <b>7928 W. 4th Ave Overland Park, KS</b>		22c. DATE SIGNED <b>5-30-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-31-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairmount</b>		23d. LOCATION (City, town, or county) (State) <b>Denver, Colorado</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Freeman Mortuary K. C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>5-31-57</b>		26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>			



*H. C. Barn*  
*8337 Foster*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed..... *Clayton K. Barn*

Licensed Embalmer No. *47*

P. O. Address *K.C.*

**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.**