

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1957

24449
STATE FILE NUMBER
3199

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

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	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		Length of stay in lb 28	
3. NAME OF DECEASED (Type or print) First Peggy Middle F. Last Cannon		4. DATE OF DEATH Month 7 Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1903
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	10c. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William Chambers		13b. MOTHER'S MAIDEN NAME Mattie Osborne	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Record Clerk	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of breast		INTERVAL BETWEEN ONSET AND DEATH 170x	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 June 22, 1957 to July 6, 1957 and last saw her live on July 6, 1957 Death occurred at 7:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE B. I. Burns (Degree or title) M.D.	
22b. ADDRESS 24th & Cherry		22c. DATE SIGNED 7-8-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem	23b. DATE 7-10-57	23c. NAME OF CEMETERY OR CREMATORY Mt Calvary	23d. LOCATION (City, town, or county) (State) Kans City Kans
24. FUNERAL DIRECTOR B.E. Weiler		25. DATE RECD. BY LOCAL REG. 7-10-57	26. REGISTRAR'S SIGNATURE Norm Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

Blaine E. Wheeler

Licensed Embalmer No. 4075

P. O. Address R.C. 817

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.