

FILED OCT 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32105

4416

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No.		
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Kansas COUNTY Wyandotte				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 7, Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		g 11 1/2		
d. FULL NAME OF HOSPITAL OR INSTITUTION Wynn Rest Home 2905 Forest				d. STREET ADDRESS (If rural, give location) 2034 N. Hallock				
3. NAME OF DECEASED (Type or Print) a. (First) Lottie b. (Middle) c. (Last) Poner			4. DATE OF DEATH (Month) (Day) (Year) 9, 16, 1957					
5. SEX F	3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH 6/12/ 1891		9. AGE (In years) (last birthday) 66 1/2	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) Maid			10b. KIND OF BUSINESS OR INDUSTRY Private Homes		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME James Riser			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE E.M. Poner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Ruther Riser 2034 N. Hallock K.C. Kansas				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Ht. Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart 2 mo DUE TO (c) 4 mo II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Auricular Fibrillation 2 wks						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 8-19-57, to 9-16-57, that I last saw the deceased alive on 9-16-57, and that death occurred at P m., from the causes and on the date stated above.								
23a. SIGNATURE L.S. Daigle			23b. ADDRESS 2122 E 15th K.C. Mo		23c. DATE SIGNED 9-18-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/18/57	24c. NAME OF CEMETERY OR CREMATORY Westlawn		24d. LOCATION (City, town, or county) (State) K.C. Wyandotte Kansas			
DATE REC'D BY LOCAL REG. 9-23-57		REGISTRAR'S SIGNATURE Reva Minshall		25. FUNERAL DIRECTOR'S SIGNATURE Bailey Funeral Home K.C. Kansas				



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
Student Embalmer

Signed *C. Kenneth Raymond*

Licensed Embalmer No. 12437

P. O. Address *W. C. Moore*

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 this body is not embalmed, fact should be so stated above.