

doctor, coroner, etc., make 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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32161

STATE FILE NUMBER

FILED SEP 19 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3931

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</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>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hosp</b>		Length of stay in lb <b>40 yrs.</b>	d. STREET ADDRESS <b>1601 Blue Ridge</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BEULAH E. SELLS</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>19,</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1903</b>	9. AGE (In years last birthday) <b>54 5/8</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>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Harrisonville, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Arthur Jesse Sexton</b>			14. MOTHER'S MAIDEN NAME <b>Anna Jane Harmon</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>James M. Hall, 226 So. Home, K.C. 22, Mo.</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>Cerebellar hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease</b>					<b>2 years</b>
DUE TO (c) <b>nephrosclerosis</b>					<b>?</b>
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? <b>4427</b> YES <input checked="" type="checkbox"/> NO <input 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.) <b>—</b>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <b>Aug 16, 1957</b> , to <b>Aug 19, 1957</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>Aug 19, 1957</b> Death occurred at <b>3:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>William F. Sanders</i> (Degree by title)			22b. ADDRESS <b>411 Nichols Rd. Kansas City, Mo</b>		22c. DATE SIGNED <b>Aug 21 1957</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 22, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Raytown, Missouri</b>	
24. FUNERAL DIRECTOR <b>George C. Carson, Independence, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-21-57</b>	26. REGISTRAR'S SIGNATURE <i>New Minshall</i>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
William F. Sanders



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 *J. H. Gibson*

Licensed Embalmer No. *48*

P. O. Address *Indep*

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.