

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35783

STATE FILE NUMBER

FILED NOV 5 1957

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4808

S. 300  
1-57

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>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo.</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City, North</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>K.C. Osteo. 11 &amp; Harr.</b> Length of stay in lb <b>2yrs</b>		d. STREET ADDRESS <b>2632 E. 47th St.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>MARY ELIZABETH EASTER</b>			4. DATE OF DEATH Month Day Year <b>Oct. 17, 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>Apr. 2, 1869</b>
9. AGE (In years last birthday) <b>88</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Carol Co., Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>George Kenton</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah C. Hudson</b>	14. NAME OF HUSBAND OR WIFE <b>Chas. Easter</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>490-16-2436</b>	17. INFORMANT Address <b>Mr. Charles Easter K.C. North</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>Cardiac Tamponade</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Myocardial infarction</b> DUE TO (c) <b>Coronary disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>two days</b> <b>several years</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>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <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 <b>Oct. 10, 57</b> to <b>October 17, 57</b> and last saw her alive on <b>10-17-57</b> Death occurred at <b>5:01 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>G. N. Gillum</b>		22b. ADDRESS <b>926 E. 11th St., K.C., Mo.</b>	22c. DATE SIGNED <b>10-18-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 19, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	23d. LOCATION (City, town, or county) (State) <b>Indep, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>OTT &amp; MITCHELL INDEP, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>10-18-57</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>

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

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

G. N. Gillum

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 *Henry H. Mitchell*

Licensed Embalmer No. *3975*  
P. O. Address *Dundee, Mo.*

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.

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