

Health,  
& Welfare  
Public  
Service

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36080  
STATE FILE NUMBER  
4462

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

S. 300  
r. 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>Mo.</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 type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Breighton Nursing Home 3400 Campbell</b>		Length of stay in lb <b>37 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>3701 Broadway</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Deyo</b> Middle <b>L.</b> Last <b>Ramsdell</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1957</b>		
5. SEX <b>Male</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>Dec. 3, 1866</b>	9. AGE (In years last birthday) <b>91-90</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>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Doctor</b>	11. BIRTHPLACE (City and state or country) <b>Kalamazoo Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William Ramsdell</b>		13b. MOTHER'S MAIDEN NAME <b>Henrette Eberstien</b>		14. NAME OF HUSBAND OR WIFE <b>Gertrude Ramsdell</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. Gertrude Ramsdell 3701 Broadway</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>Hypostatic Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b> <b>4500</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? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
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>Sept 19</b> to <b>50-9-22-57</b> and last saw <sup>him</sup> alive on <b>9-22-57</b> Death occurred at <b>12:10 PM 9-22-57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (In free or title) <b>Chester E. Lee M.D.</b>			22b. ADDRESS <b>5830 Nall Mission Kansas</b>		22c. DATE SIGNED <b>9-24-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>Entombment</b>		<b>9/27/57</b>	<b>Mt Moriah</b>		<b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure K.C.Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>9-25-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>	

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Chester E. Lee



5830 Hall Ave  
with Dr in office 9:30 AM to 1:30 PM.

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 *Eugene L. Hamer*

Licensed Embalmer No. *4633*

P. O. Address *..... City*

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.