

pt. Health,
r. & Welfare
S. Public
alth Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38949

FILED NOV 12 1957

STATE FILE NUMBER

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 175

S. 300
ev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Kansas City 3618</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3</u>		d. STREET ADDRESS (If outside, give location) <u>4417 College</u>	
Length of stay in lb <u>1 mo 28 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>OLIVA</u> Middle <u>MARIE</u> Last <u>CUMMINGS</u>			4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1957</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1901</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soda fountain clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Carl Thomas</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Shoup</u>	14. NAME OF HUSBAND OR WIFE <u>Finis K. Cummings</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>495-09-1406</u>	17. INFORMANT <u>Hospital records</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Severe cachexia</u>		<u>months</u>
DUE TO (c) <u>Psychotic agitated depression</u>		<u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>		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.)
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20c. TIME OF INJURY Hour <u>8:05 p</u> Month <u>10</u> Day <u>26</u> Year <u>1957</u>	20d. INJURY OCCURRED WHILE AT <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 <u>Kansas City</u>	COUNTY <u>Missouri</u>	STATE
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21. I attended the deceased from <u>8/29/57</u> to <u>10/26/57</u> and last saw her alive on <u>10/26/57</u> Death occurred at <u>8:05 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3</u>	22c. DATE SIGNED <u>10/26/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-27-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flora Hills</u>	23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Flora Hills Inc, Kansas City, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-7-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 RUBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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NOV 13 1957

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 *Percy F. Milster*

Licensed Embalmer No. *4805*

P. O. Address *Nevada, 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.