

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40264
STATE FILE NUMBER
4924
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		Length of stay in 1b 19 Days.		d. STREET ADDRESS 318 Greeley		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Claxton Last Claxton				4. DATE OF DEATH Month 10/ Day 21/ Year 1957			
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1928		9. AGE (In years last birthday) 29	10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Johnnie Claxton			13b. MOTHER'S MAIDEN NAME Lula Williams		14. NAME OF HUSBAND OR WIFE None		
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. -		17. INFORMANT Address Mrs Mary Claxton K.C. Kansas			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____					
		DUE TO (c) Pending Laboratory Report					
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 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.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 10/21/1957							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 24th St Terrace Indiana		20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, Mo		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him live on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Deputy Coroner				22b. ADDRESS 1618 Lydia Ave		22c. DATE SIGNED 10/22/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/24/57	23c. NAME OF CEMETERY OR CREMATORY Westlawn		23d. LOCATION (City, town, or county) (State) K.C. Wyandotte Kansas		
24. FUNERAL DIRECTOR Bailey Funeral Home K.C. Kansas			25. DATE RECD. BY LOCAL REG. 10-24-57		26. REGISTRAR'S SIGNATURE Reva Marshall		

L. M. Tillman
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.



Or 1-28-3

Mar 1-5-181
Child 11-20

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 Landis H. Jackson

Licensed Embalmer No. 4858
P. O. Address R. E. 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.