

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40536

FILED DEC 5 - 1957

STATE FILE NUMBER
5488

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5538 OLIVE ST.		Length of stay in 1b 75 YEARS	d. STREET ADDRESS (If outside, give location) 5538 OLIVE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDNA Middle R. Last PARRY			4. DATE OF DEATH Month NOVEMBER Day 19 Year 1957
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9 1880
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE-AT HOME	11. BIRTHPLACE (City and state or country) ATCHISON, KANSAS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME PETER DE GARNO SUTTON	13b. MOTHER'S MAIDEN NAME MARY ALAN
14. NAME OF HUSBAND OR WIFE William A.B. PARRY		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. NONE
17. INFORMANT Address Mrs. EDWARD M. WHEAT. 5538 OLIVE, K.C. Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
INTERVAL BETWEEN ONSET AND DEATH 2 Yr.		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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 COUNTY STATE	
21. I attended the deceased from 1950 to 11-19-57 and last saw her/him alive on 11-12-57 Death occurred at 7:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. R. Lyndon, Jr. (Degree or title) MD		22b. ADDRESS 1027 E 75, K.C. MO	
22c. DATE SIGNED 11-19-57		23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	
23b. DATE Nov. 20, 1957		23c. NAME OF CEMETERY OR CREMATORY D.W. NEWCOMER'S SONS	
23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI		24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS. ADDRESS 1301 BROWN CREEK KANSAS CITY, MO.	
25. DATE RECD. BY LOCAL REG. 11-20-57		26. REGISTRAR'S SIGNATURE Neva Minshall	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
H. R. Lyndon, Jr.



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 *Basil V. Honey*

Licensed Embalmer No. *4724*

P. O. Address *K.C., 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.