

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40593  
STATE FILE NUMBER  
5491

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5491

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>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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hosp.</b>		Length of stay in lb <b>11 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>215 W. 68th Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Elsie Scott</b>			4. DATE OF DEATH Month Day Year <b>Nov. 18, 1957</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>Nov. 14, 1901</b>
9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	11. BIRTHPLACE (City and state or country) <b>Northville, South Dakota</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Clyde E. Evans</b>	
13b. MOTHER'S MAIDEN NAME <b>Esther Osburne</b>		14. NAME OF HUSBAND OR WIFE <b>Guy R. Scott</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>Guy R. Scott 215 West 68th, KC, Mo.</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>Fractures RT clavicle, multiple ribs LT humerus, 9th thoracic vertebrae, compression of thoracic spinal cord due to hematoma, multiple contusions.</b>			INTERVAL BETWEEN ONSET AND DEATH. <b>3 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>multiple contusions.</b> DUE TO (c)			<b>E978X</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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Patient jumped out of 4th floor hospital window</b>	
20c. TIME OF INJURY Hour Month, Day, Year <b>(P.M.) 5:05 - 11-18-57</b>		<b>11-18-57.</b>	
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.) <b>St Luke's Hosp.</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson Mo.</b>
21. I attended the deceased from <b>1955</b> to <b>Nov. 18, 57</b> and last saw her alive on <b>Nov. 18, 57</b> Death occurred at <b>7:45 P.M. - Nov. 18, 57</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. W. Robinson M.D.</b> (Degree or title)		22b. ADDRESS <b>4635 Argonne</b>	22c. DATE SIGNED <b>11-19-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-20-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b> ADDRESS <b>Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-20-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</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  
A.W. Robinson

92-1-033-2  
2:00PM



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 *J. S. Walton* .....

Licensed Embalmer No. *2744* .....

P. O. Address *KC 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.