

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1448
STATE FILE NUMBER
303

FILED FEB 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 303

1. PLACE OF DEATH a. COUNTY <u>Jackson</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>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTE <u>Beal Jones Res Home 65y.</u>		d. STREET ADDRESS (If outside, give location) <u>137 Cypress</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>-</u> Last <u>Springer</u>			4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June-12-1868</u>
9. AGE (In years less birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	10. USUAL OCCUPATION (Give kind of work done and longest of working life even if retired) <u>Housewife</u>
11. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	12. BIRTHPLACE (City and state or country) <u>Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Ernest C. Springer</u>	
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>-</u>	17. INFORMANT Address <u>137 Cypress</u> <u>Mrs. Thomas Stanley</u> <u>K.C. Mo.</u>	
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>Arteriosclerotic heart disease</u>			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) _____			<u>4200</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arthritis of spine</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.)		
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 _____, to _____ and last saw her/him alive on _____ <input checked="" type="checkbox"/> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. L. Dwyer M.D.</u> (Degree or title)		22b. ADDRESS <u>City Hall K.C. Mo.</u>	22c. DATE SIGNED <u>1-20-58</u>
23a. BURIAL, CREMATION, REMOV. (Specify) <u>Cremation</u>	23b. DATE <u>1-20-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>C. H. Blackman Son Inc. K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-30-58</u>	26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
H. L. Dwyer

All diseases in Part I must be causally related.

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 *Bert B. Bennett*

Licensed Embalmer No. *4656*

P. O. Address *H. 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.