

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005499
STATE FILE NUMBER

FILED MAR 3 - 1958

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 637

300
-57

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 3635 Flora		Length of stay in lb 30 yrs	d. STREET ADDRESS 3635 Flora (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SARAH Middle ISABELL Last FLEMING			4. DATE OF DEATH Month 2 Day 7 Year 58		
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1870	9. AGE (In years at birthday) 87	FUNDER YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (City and state or country) No Burlington, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Shearer	13b. MOTHER'S MAIDEN NAME Margaret Grogan	14. NAME OF HUSBAND OR WIFE Hugh Fleming
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Chas. Duncan, 5101 Wyandotte	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) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH H. 10
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 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 WORK <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 Afton, Iowa	COUNTY Afton	STATE Iowa
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
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 (Degree or title) Hugh H. Owens Coroner	22b. ADDRESS 1034 Piatt Bldg	22c. DATE SIGNED 2-7-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-7-58	23c. NAME OF CEMETERY OR CREMATORY Afton Cemetery	23d. LOCATION (City, town, or county) (State) Afton, Iowa
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24. FUNERAL DIRECTOR Wagner Funeral Home	ADDRESS K 6 Mo	25. DATE RECD. BY LOCAL REG. 2-7-58	26. REGISTRAR'S SIGNATURE Neva Minshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in their report. No symptoms or signs must be causally related. All diseases in Part I must be causally related.

Hugh H. Owens



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 *Thomas P. Kerk*

Licensed Embalmer No. *4995*

P. O. Address *T. 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.