

FILED MAR 10 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005848
STATE FILE NUMBER 861

Registration District No. 149 Primary Registration District No. 1000 Registrar's No. _____

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 1614 Lydia Ave		Length of stay in lb 7 Yrs.	d. STREET ADDRESS (If outside, give location) 1614 Lydia		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harvey Middle _____ Last Shrout			4. DATE OF DEATH Month 2- Day 13- Year 58		
5. SEX Male	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 Mar. 7, 1877		9. AGE (In years, last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) Kansas	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Shrout		13b. MOTHER'S MAIDEN NAME Ida	
14. NAME OF HUSBAND OR WIFE Acy Shrout		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Acy Shrout		Address 1614 Lydia Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure					INTERVAL BETWEEN ONSET AND DEATH 17 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis & hypertensive cardiovascular disease					many years
DUE TO (c) _____					4432
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 _____ 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 20 October 1951 , to 13 February 1958 and last saw ^{her} alive on 13 February 1958 Death occurred at 12:15 PM on the date stated above; and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE <i>[Signature]</i>			22b. ADDRESS 1103 Grand Ave.		22c. DATE SIGNED 14 Feb-1958
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-17-58	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Manlove-William			25. DATE RECD. BY LOCAL REG. 2-17-58		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION
B. A. Lieberman, M.D., USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms when to be reported.



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 *E. J. Mendore*

Licensed Embalmer No. 3994.....
P. O. Address 3712 E 307.....

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.