

FILED MAR 7 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006037
STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 7

300
-57

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>GRANDVIEW</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HICKMAN MILL'S</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>PRINNINGTON RESIDENCE</u> INSTITUTION <u>13007SO. 13TH STREET</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>R.R. #19</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>FRANCES</u> Last <u>FIELD</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>23</u> Year <u>1958</u>		
--	--	--	--	--	--

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-27-1887</u>	9. AGE (In years last birthday) <u>70</u>	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) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	--	---	---

13a. FATHER'S NAME <u>JACK ASHWORTH</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>ROY FIELD</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>NONE</u>	17. INFORMANT <u>ROY FIELD</u> Address <u>R-R. #19 HICKMAN MILL'S, 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>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>
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 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.) <u>331X</u>
---	---

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 <u>22 Feb 58</u> to <u>23 Feb 58</u> and last saw her alive on <u>Feb 22, 1958</u> Death occurred at <u>8:26 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>William R. Roberts, MD</u>	22b. ADDRESS <u>12921 Grandview Rd</u>	22c. DATE SIGNED <u>2-24-58</u>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB-25-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
--	---------------------------------	---	--

24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>	ADDRESS <u>KANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>2/24/58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	-----------------------------------	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 5 1968

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 Chester K. Brown

Licensed Embalmer No. 4931

P. O. Address K O 770

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.