

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009911
STATE FILE NUMBER
1156

FILED MAR 19 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 1156

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp., 20 years</u>		d. STREET ADDRESS (If outside, give location) <u>4123 Bell St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Ruth</u> Last <u>Eads</u>		4. DATE OF DEATH Month <u>3</u> Day <u>-2</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>1-9-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee - Drummond Cleaners</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaners</u>	11. BIRTHPLACE (City and state or country) <u>Bernard, Missouri</u>
13a. FATHER'S NAME <u>Samuel A. Wohlford</u>		14. NAME OF HUSBAND OR WIFE <u>Dewey Eads</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		17. INFORMANT Address <u>Hosp. Records Dewey Eads 4123 Bell</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>Acute Pneumococcal Meningitis</u> DUE TO (b) <u>Bilateral Lobar Pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>490 h</u>
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>1</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 COUNTY STATE	
21. I attended the deceased from <u>12 AM 3-1-58</u> to <u>4 PM 3-2-58</u> and last saw her alive on <u>3-2-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. F. Sewell M.D.</u>		22b. ADDRESS <u>1725 W 39th Mo</u>	
22c. DATE SIGNED <u>3-3-58</u>		22d. DATE RECD. BY LOCAL REG.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-2-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>-</u>		23d. LOCATION (City, town, or county) (State) <u>MARYVILLE, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomers Sons - N.K.C.</u>		25. DATE RECD. BY LOCAL REG. <u>3-4-58</u>	
26. REGISTRAR'S SIGNATURE <u>New Marshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

M. F. Sewell

Dr M.F. Sewell - 1722 W. 39th - (Va. - 1-5883)

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 *John W. Halebeck*
Licensed Embalmer No.....

P. O. Address.....

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.