

Health, Welfare
Public
Service

FILED APR 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009936
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1515

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>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) HOSPITAL OR INSTITUTION <u>Research Hospital</u>		Length of stay in 1b. <u>65 yrs. 3</u>	d. STREET ADDRESS (If outside, give location) <u>211 E. Winthrop</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Frank</u> Last <u>Fleming</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</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>Aug. 18, 1892</u>	9. AGE (In years last birthday) <u>65</u>	IF FUNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Sales</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas A. Fleming</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Aurelia Fleming</u>
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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) <u>NO</u> <u>W.W.I.</u>	16. SOCIAL SECURITY NO. <u>494-14-3547</u>	17. INFORMANT <u>MRS. Aurelia Fleming 211 E. Winthrop</u>
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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) <u>602emia</u> <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3/16/58</u> <u>331 1/2</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 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.) <u>2</u>
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20c. TIME OF INJURY Hour <u>0</u> Month, Day, Year <u>3/16/58</u> a.m. <u>0</u> p.m. <u>0</u>	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 <u>Kansas City</u>	COUNTY <u>Missouri</u>	STATE
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21. I attended the deceased from Death occurred at <u>3/16/58</u> to <u>3/22-58</u> and last saw ^{him} <u>3/22/58 AM</u> alive on <u>3/22/58 AM</u> m of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ed Saladino, M.D.</u> (Degree or title)	22b. ADDRESS <u>1040 Argyle Bldg</u>	22c. DATE SIGNED <u>3/23/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 29/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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24. FUNERAL DIRECTOR <u>Muehlebach</u>	ADDRESS <u>6800 TRUST</u>	25. DATE RECD. BY LOCAL REG. <u>3-23-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
A. Saladino

Doctor, coroner, etc. must use only standard nomenclature in reporting cause of death. All diseases in Part I must be causally related.

Dr. J. J. [unclear]

712 1st. [unclear] 9/15/51



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 *R. E. Nichols*

Licensed Embalmer No. *4997*

P. O. Address *K. 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.