

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017116

STATE FILE NUMBER

FILED MAY 1 1958

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 63

S. 300
1-57

802

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Vernon		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 Washington		c. CITY OR TOWN Kansas City 35180	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #3		d. STREET ADDRESS (If outside, give location) 3635 Campbell	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph G. Suor			4. DATE OF DEATH Month Day Year 4-13-58
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1880
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and state or country) New York (state) /
13a. FATHER'S NAME Lambert Suor		13b. MOTHER'S MAIDEN NAME Elizabeth Kelly	14. NAME OF HUSBAND OR WIFE Evaline C. Sour
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown (If yes, give war or dates of service)) Unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Adm Papers
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 1 week
DUE TO (b) Fct. Left Hip			12 Days
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senil Dementia			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT <input checked="" 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.) Was in stool room, 12.30Am Sliped fellhad to be carried to his bed	
20c. TIME OF INJURY Hour Month, Day, Year 12.30a.m. 4-1-58			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) State Hosp. # 3	20f. CITY, TOWN, OR LOCATION Washington	COUNTY STATE Vernon 108 Missouri
21. I attended the deceased from 9-12-57 to 4-13-58 and last saw him alive on 4-13-58 Death occurred at 1.05 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edmund P. Reynolds, M.D.		22b. ADDRESS Meriden, Mo.	22c. DATE SIGNED 4-13-58
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal 4-13-58		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Stine & McClure-Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 4-15-1958	26. REGISTRAR'S SIGNATURE Anna J. Ferry

MAY 1 1958

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 *Seely F. Melster*
Licensed Embalmer No. *4805*
P. O. Address *Meriden, 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.