

Health,
& Welfare
Public
Service

S. 300
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018082

STATE FILE NUMBER
2464

FILED MAY 29 1958

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

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 RESEARCH HOSPITAL Length of stay in 1b 25 YEARS		d. STREET ADDRESS (If outside, give location) 1213 EAST 36 TH STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last FRANCES JOLURA CLINE			4. DATE OF DEATH MAY 13, 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB 25, 1915
9. AGE (In years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. KIND OF BUSINESS OR INDUSTRY DOMESTIC		12. BIRTHPLACE (City and state or country) OSBORN, MISSOURI	
13. FATHER'S NAME WILLIAM THOMAS HACKETT		14. MOTHER'S MAIDEN NAME ADA WINGATE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GEORGE F. CLINE		Address 1213 EAST 36 TH STREET KANSAS CITY MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX			INTERVAL BETWEEN ONSET AND DEATH 6 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			171*
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 10-14-57 to 5-13-58 and last saw her alive on 5-13-58 Death occurred at 11:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Samuel B. Chapman M.D.		22b. ADDRESS 830 Argyle Bldg Kansas City Mo.	
		22c. DATE SIGNED 5-14-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 15 1958	
23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 5-15-58	
ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO		26. REGISTRAR'S SIGNATURE neva minshall	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Samuel B. Chapman

(Licensed Embalmer's Statement on Reverse Side)



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 *James W. Brown*

Licensed Embalmer No. *4889*

P. O. Address *A.C. No.*

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.