

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025308

STATE FILE NUMBER

FILED JUL 17 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3127

S. 300  
v. 1-57  
360

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3116 Pennsylvania</b>		Length of stay in lb <b>30 months</b>	d. STREET ADDRESS (If outside, give location) <b>3116 Pennsylvania</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>DELLA ABELL</b>			4. DATE OF DEATH <b>June 23, 1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 20, 1870</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K.C.K. Bd of Ed.</b>	11. BIRTHPLACE (City and state or country) <b>Paris, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Thomas Walsh</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Jane McDonald</b>		14. NAME OF HUSBAND OR WIFE <b>Wm. F. Abell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Miss Ada Walsh 3116 Pennsylvania K.C.Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>4-20</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Sclerosis</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.) <b>—</b>			
20c. TIME OF INJURY Hour a.m. p.m. <b>—</b>					
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.) <b>—</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1-1-56</b> to <b>6-23-58</b> and last saw her alive on <b>4-23-58</b> Death occurred at <b>6/23/58 10:35 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>J. G. Evans, MD</b>			22b. ADDRESS <b>Huron Bldg. K.C.K</b>		22c. DATE SIGNED <b>6/23/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>6/26/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Francis Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Paul, Ks.</b>
24. FUNERAL DIRECTOR <b>JOS. A. BUTLER'S SONS</b>			ADDRESS <b>K.C.K</b>	25. DATE RECD. BY LOCAL REG. <b>6-25-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.



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

*Russell W Dennis*

Licensed Embalmer No. *3462*

P. O. Address *Kansas City 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.