

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032649
STATE FILE NUMBER

1958 OCT 15 149 Registration District No. Primary Registration District No. 1002 Registrar's No. 4560

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kansas</i> b. COUNTY <i>Wyandotte</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> 815 S
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>3522 Walnut</i>		Length of stay in lb <i>46 days</i>	d. STREET ADDRESS (If outside, give location) <i>1870 N. 36th</i>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>Amy</i> Middle <i>Elder</i> Last <i>Elder</i>			4. DATE OF DEATH Month <i>Sept</i> Day <i>26</i> Year <i>1958</i>		
---	--	--	--	--	--

5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 18, 1873</i>	9. AGE (In years) <i>85</i> UNDER 1 YEAR IF UNDER 24 HRS. Last birthday Months Days Hours Min.	
----------------------	-------------------------------	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	11. BIRTHPLACE (City and state or country) <i>Alva, Nebraska</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
---	--	---	---

13a. FATHER'S NAME <i>Wesley Bird</i>	13b. MOTHER'S MAIDEN NAME <i>Clemma Bates</i>	14. NAME OF HUSBAND OR WIFE <i>Unknown</i>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Frank Hughes, K. C., Kansas</i>	Address
---	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arteriosclerosis, Generalized.</i>		<i>10 yrs.</i>
	DUE TO (c) <i>Arthritis, Generalized.</i>		<i>20 yrs.</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>331X</i>		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.)
---	--

20c. TIME OF INJURY Hour <i>8:30 p.m.</i> Month, Day, Year	
---	--

20d. INJURY OCCURRED WHILE AT WORK <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.)	20f. CITY, TOWN, OR LOCATION <i>Mankato, Kansas</i>	COUNTY <i>Kansas</i>	STATE
---	--	--	-------------------------	-------

21. I attended the deceased from <i>8-10-58 to 9-26-58</i> and last saw her/him alive on <i>9-26-58</i> Death occurred at <i>8:30 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Wallace H. Graham, M.D.</i> (Degree or title)	22b. ADDRESS <i>518 Angell Bldg. H. C. Mo.</i>	22c. DATE SIGNED <i>9-27-58</i>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>9-27-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>-</i>	23d. LOCATION (City, town, or county) (State) <i>Mankato, Kansas</i>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <i>Kramer Mortuary, Mankato, Kansas</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>9-27-58</i>	26. REGISTRAR'S SIGNATURE <i>Irene Minshall</i>
---	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

Wallace H. Graham use only black ink or ribbon typewrite if possible

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



7/11
1-6/11
will call

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 R. Didman*

Licensed Embalmer No. *4531*
P. O. Address *Kansas*

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.