

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033036
STATE FILE NUMBER
4466

FILED OCT 8 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4466

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY of Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Mission Township	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 2706 West 79th St.	
3. NAME OF DECEASED (Type or print) First John Middle A. Last Teeters		4. DATE OF DEATH Month September Day 19 Year 1958	
5. SEX Male	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 2-17-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. - Treas.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Pennsylvania
13a. FATHER'S NAME C. H. Teeters		13b. MOTHER'S MAIDEN NAME Sarah J. Armstrong	14. NAME OF HUSBAND OR WIFE Florence M. Teeters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. 707-16-5838	17. INFORMANT Address Florence M. Teeters, 2706 West 79th.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOCYTOPENIA PURPURA IDIOPATHIC. DUE TO (b) SUBARACHNOID HEMORRAGE DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 12 HRS.
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 _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 9-15-58 to 9-19-58 and last saw her/him alive on 9-18-58 Death occurred at 8:15 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward P. Altomare M.D.		22b. ADDRESS 2610 E 63rd St.	22c. DATE SIGNED 9-20-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-21-1958	23c. NAME OF CEMETERY OR CREMATORY Rose Hill	23d. LOCATION (City, town, or county) (State) Chickasha, Oklahoma
24. FUNERAL DIRECTOR ADDRESS Line & McClure Undertaking Co, KC, Mo.		25. DATE RECD. BY LOCAL REG. 9-20-58	26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
Edward P. Altomare USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

See Ed Johnson

DA-33311

2610 E 63rd

Mem. will enter
2015 on June 1st 2015

ST. Joseph Hosp. 2015

Chicago, Ill. U.S.A.

James J. Johnson

11/15/15

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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 *Eugene Johnson*

Licensed Embalmer No. *463*
P. O. Address *R E Johnson*

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.