

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036338  
STATE FILE NUMBER

FILED NOV 14 1958 Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 5021

300  
1-57

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>CLAY</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 NORTH</b> 55 <sup>th</sup> ST 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>ST. JOSEPH HOSPITAL</b>		Length of stay in 1b <b>25 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>6607 E. 49<sup>th</sup> STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIE</b> Middle <b>CURT</b> Last <b>DEARMAN</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>22</b> Year <b>1958</b>			
---	--	--	--	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 4, 1911</b>	9. AGE (In years last birthday) <b>47</b>	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours	12. UNDER 24 HRS. Min.
--------------------	-------------------------------	---	---	--	----------------------------	----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING CLERK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>W. E. YOUNG PLUMBING Co.</b>	11. BIRTHPLACE (City and state or country) <b>HORATIO, ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	--	--	---

13a. FATHER'S NAME <b>EDWARD DEARMAN</b>	13b. MOTHER'S MAIDEN NAME <b>RHOADA COLEY</b>	14. NAME OF HUSBAND OR WIFE <b>PAULINE DEARMAN</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>495-20-4402</b>	17. INFORMANT <b>MRS. PAULINE DEARMAN, 6607 E. 49<sup>th</sup> ST. K.C. MO.</b>	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) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary insufficiency marked</b>	
	DUE TO (c) <b>Arteriosclerosis</b>	

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 <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>U.S.A.</b>
---	---

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 <b>7-22-55</b> to <b>10-22-58</b> and last saw him alive on <b>10-22-58</b> Death occurred at <b>10:55 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <b>J. M. Haight</b> (Degree or title)	22b. ADDRESS <b>3401 @ 12<sup>th</sup> St. K.C. Mo</b>	22c. DATE SIGNED <b>10-24-58</b>
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 25, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	23d. LOCATION (City, town, or county) <b>KANSAS CITY MISSOURI</b>
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK BLVD. KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>10-25-58</b>	26. REGISTRAR'S SIGNATURE <b>Walter Marshall</b>
---	---	---

All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 J. M. Haight



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 Basil P. Honey, .....

Licensed Embalmer No. 4724, .....

P. O. Address F.C., 30, Md. ....

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.