

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039920
STATE FILE NUMBER
5257

FILED NOV 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5257

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 260
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2739 Bales		Length of stay in lb 56 yrs.	d. STREET ADDRESS (If outside, give location) 2739 Bales
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last DORA M. DREW			4. DATE OF DEATH Month Day Year November 4, 1958		
--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1885	9. AGE (In years last birthday) 73 yrs.	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
------------------	---------------------------	---	------------------------------------	--	---	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jefferson City, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	--	-------------------------------------

13a. FATHER'S NAME John Hardy	13b. MOTHER'S MAIDEN NAME Mariah Hughes	14. NAME OF HUSBAND OR WIFE Charles L. Drew
----------------------------------	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 495-05-3545	17. INFORMANT D Hazel Wyatt	Address 2739 Bales St.	Relationship Daughter
---	--	--------------------------------	---------------------------	--------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation & Pulmonary Edema 10d DUE TO (b) Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 4200	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			

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 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 10-26-58 to 11-4-58 and last saw her alive on 11-1-58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE J. S. Johnson, M.D.	(Degree or title) D	22b. ADDRESS 2202 E 18th St.	22c. DATE SIGNED 11-5-58
---------------------------------------	---------------------	---------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-8-58	23c. NAME OF CEMETERY OR CREMATORY Lincoln	23d. LOCATION (City, town, or country) (State) Kansas City, Missouri
---	----------------------	---	---

24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th & Benton	ADDRESS	25. DATE RECD. BY LOCAL REG. 11-6-58	26. REGISTRAR'S SIGNATURE neva Marshall
--	---------	---	--

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. S. Johnson

MEDICAL CERTIFICATION



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 *Anna P. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18th & Bent*

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.