

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040276

STATE FILE NUMBER

FILED NOV 19 1958

Registration District No. 149

Primary Registration District No. 1007

Registrar's No. 5129

300
-57

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 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPHS HOSP		Length of stay in lb 10 yrs.	d. STREET ADDRESS (If outside, give location) 3304 FOREST Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SARAH Middle NEEMA Last WESTON			4. DATE OF DEATH Month OCT. Day 30 Year 1958		
---	--	--	--	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July-14-1899	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	---	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY SERVICE ADVANCE EMPLOYMENT	11. BIRTHPLACE (City and state or country) ASH GROVE, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	---

13a. FATHER'S NAME JOSEPH JOHNSON	13b. MOTHER'S MAIDEN NAME ALBERTA JANE DANIEL	14. NAME OF HUSBAND OR WIFE CHARLES WESTON
---	---	--

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. 495-10-7906	17. INFORMANT Address DOYLE DANIEL - ASH GROVE, MISSOURI
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-Surgical Shock Interval between ONSET AND DEATH 2 Days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Intestinal Obstruction Partial Interval between ONSET AND DEATH 4 years
	DUE TO (c) Duodenal Ulcer, Recurrent Interval between ONSET AND DEATH 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) 5418	
19. YES AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	

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. Month, Day, Year 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 **June 1956** to **Oct 1958** and last saw her alive on **Oct 28 1958**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A.D. Eshelman M.D.	22b. ADDRESS 9306 E New 40 Hwy Independence Mo.	22c. DATE SIGNED 10-30-58
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV. 1, 1958	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
--	----------------------------------	--	---

24. FUNERAL DIRECTOR D.W. NEWCOMERS SONS - KANSAS CITY, MO	25. DATE RECD. BY LOCAL REG. 11-1-58	26. REGISTRAR'S SIGNATURE Irma Marshall
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
A. D. Eshelman

All diseases in Part I must be causally related.

2
A

DEC 29 1958

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 *Ray L. Samuel*

Licensed Embalmer No. *4702*

P. O. Address *Box 37086-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.