

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044377  
STATE FILE NUMBER 5705

FILED DEC 18 1958

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5705

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>KANSAS</b> b. COUNTY <b>Douglas</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>LA WRENCE</b> <sup>8150</sup> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>A HOSPITAL</b>		Length of stay in 1b <b>1/2 hour</b>	d. STREET ADDRESS (If outside, give location) <b>1230 NEW YORK ST</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>ASHLEY</b> Last <b>SANDEFUR</b>	4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1958</b>
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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>February 21, 1894</b>	9. AGE (In years at birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-retired</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Chaney, Oklahoma</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Icyrus Sandefur</b>	13b. MOTHER'S MAIDEN NAME <b>Providence Hipsley</b>	14. NAME OF HUSBAND OR WIFE <b>Florence SANDEFUR</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Official Records, VA Hospital, K. C. Mo.</b>	Address
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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>Congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic heart disease</b>	
	DUE TO (c) _____	
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? <b>1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>LA WRENCE</b>	COUNTY <b>Douglas</b>	STATE <b>KANSAS</b>
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21. I attended the deceased from <b>November 30, 1958</b> to <b>November 30, 1958</b> Death occurred at <b>2:00</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Walter H. Owens</i>	(Degree or title) <b>1034</b>	22b. ADDRESS <b>1034</b>	22c. DATE SIGNED <b>12-2-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>DEC. 4, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	23d. LOCATION (City, town, or nearby) <b>KANSAS CITY, MISSOURI</b>	(State)
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRASH CREEK KANSAS CITY, MO</b>	25. DATE RECD. BY LOCAL REG. <b>12-2-58</b>	26. REGISTRAR'S SIGNATURE <i>neva minshall</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
High H. Owens

All diseases in Part I must be causally related.  
Dolor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.



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 Chester K Brown

Licensed Embalmer No. 493

P. O. Address KEMO

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.