

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000631
STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 11

300
-57

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Smithville TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY (OR TOWN) (Oakwood) Kansas City 16,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Smithville Hospital		Length of stay in lb 4 days	d. STREET ADDRESS (If outside, give location) 809 Maple Dr.
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Mrs. Stella Middle Bade Last Bade			4. DATE OF DEATH Month January Day 15, Year 1959		
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5. SEX Female	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 July 16, 1889	9. AGE (In years at birthday) 69	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Pleasant Hill, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME John P. Clements	13b. MOTHER'S MAIDEN NAME o	14. NAME OF HUSBAND OR WIFE Mr. Albert Bade
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Albert Bade-809 Maple Dr.-Kansas C. 16, Mo.	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) Kimmelstiel Wilson Disease		INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Diabetes mellitus		Unknown
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia one month before death 260X		19. WAS 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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		

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
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21. I attended the deceased from **12-16-58** to **1-15-59** and last saw ^{her} alive on **1-15-59**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald E. Ruency M.D. (Degree or title)	22b. ADDRESS Rte 1 Box 19 Cashland Mo	22c. DATE SIGNED Jan 16, 1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-19-1959	23c. NAME OF CEMETERY OR CREMATORY White Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Clay County, Missouri
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons-No. Kansas City, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 1-19-59	26. REGISTRAR'S SIGNATURE Marquette Hudgens
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Glen A. Hill*

Licensed Embalmer No. *4586*

P. O. Address *K.C. 16. 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.