Health, Welfare Public Service

300 -57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004850

STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 834

1. PLACE OF DEATH
a. COUNTY Clay
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5537 Bennington — Length of stay in Ib Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Clay
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 5537 N Bennington (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Sarah Middle Jane Last Newkirk

4. DATE OF DEATH Month Feb Day 11 Year 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Oct 29 1877

9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

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) Platte County Mo

12. CITIZEN OF WHAT COUNTRY? U. S A

13a. FATHER'S NAME John Stilwagon

13b. MOTHER'S MAIDEN NAME Georgia A Mitchell

14. NAME OF HUSBAND OR WIFE Cornelius Newkirk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs Ethel M. Otis Address 5537 N Bennington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH 3 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral atherosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331.4

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-12-59, to 2-11-59 and last saw her/him alive on 2-10-59
Death occurred at 9:00 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David P. Graham M.D.

22b. ADDRESS 6708 N Oak

22c. DATE SIGNED 2-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 2-14-59

23c. NAME OF CEMETERY OR CREMATORY Old German

23d. LOCATION (City, town, or county) Platte Co. (State) Mo

24. FUNERAL DIRECTOR D. W. Newcomer's Sons ADDRESS KC.

25. DATE RECD. BY LOCAL REG. 2-13-59

26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

David L. Zacharias

Dr. Zacharias

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 John W Kalsbeek

Licensed Embalmer No. 4949

P. O. Address No. Kansas

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.