

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005824

STATE FILE NUMBER

FILED FEB 27 1959

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 810

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 type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hillcrest Nursing Home		Length of stay in lb 37 YEARS	d. STREET ADDRESS (If outside, give location) 4536 JARBOE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EVA Middle ELLEN Last RAUP			4. DATE OF DEATH Month FEB Day 10 Year 1959		
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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 FEB. 17-1868	9. AGE (In years last birthday) 90	10. UNDER 1 YEAR Months _____ Days _____	11. 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) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state) OTTUMWA IOWA	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME DANIEL HOVEY	13b. MOTHER'S MAIDEN NAME JANE ELLIS	14. NAME OF HUSBAND OR WIFE CHARLES A. RAUP
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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 ALBERT J. RAUP - 4536 JARBOE Address KANSAS CITY, MO
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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) Hypostatic pneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	
	DUE TO (c) Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility - Malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

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"/> 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 May 58 , to 2-9-59 and last saw her alive on 2-9-59 Death occurred at 1:50 A. m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE James D Dunleavy MD (Degree or title)	22b. ADDRESS 314 Withman Bldy KC MO	22c. DATE SIGNED 2-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE FEB. 12, 1959	23c. NAME OF EMPLOYER OR CREMATORY D. W. NEWCOMER'S SONS	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR D.W. Newcomers Sons - KANSAS CITY, MO	1351 DR BRUSH CREEK	25. DATE RECD. BY LOCAL REG. 2-12-59	26. REGISTRAR'S SIGNATURE neva minshall
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(Licensed Embalmer's Statement on Reverse Side)

James D. Dunleavy 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 *Kennan W. Pearson*.....

Licensed Embalmer No. *4887*.....

P. O. Address *H. C. Fla.*.....

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.