

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017913

STATE FILE NUMBER
2148

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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 Research Hosp		Length of stay in lb 57 years	d. STREET ADDRESS (If outside, give location) 5344 PARK Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SARAH Middle RAMS Last RAMS			4. DATE OF DEATH Month April Day 27 Year 1959		
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5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1901	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS Hours 0 Min. 0
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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 Home	11. BIRTHPLACE (City and state or country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Oliver B. Bevis	13b. MOTHER'S MAIDEN NAME Deborah McCarly	14. NAME OF HUSBAND OR WIFE DANA W. RAMS
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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 DANA RAMS Address 5344 PARK
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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) Carcinomatous		INTERVAL BETWEEN ONSET AND DEATH 6 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of Breast	
	DUE TO (c) & Surgical Removal 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X		19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT <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 Kansas City	COUNTY Missouri	STATE
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21. I attended the deceased from May, 1957 to 4-27-59 and last saw her/him alive on 4-27-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Robert C. Mc Clanahan (Doctor or title)	22b. ADDRESS 820 Poplar Ave	22c. DATE SIGNED 4/29/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Muchlebach ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 4-29-59	26. REGISTRAR'S SIGNATURE Irene Marshall
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MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Robert C. Mc Clanahan
 All diseases in Part I must be causally related.

Rev. Mr. [unclear]
No. 1-2892 Prop. [unclear]
Ex 2-7673 Home
10:00 AM Wed.



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

R. E. Nichols

Licensed Embalmer No. *4997*

P. O. Address *K.C. 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.