

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020710

FILED JUL 8 1959

Registration District No. 323 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 2942

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Franklin Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>223 E. 45th St.</u> Length of stay in lb <u>44 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>2405 Oakley</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED c. (Type or print) First <u>Stella</u> Middle <u>Freda</u> Last <u>Trece</u>			4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March-10-1902</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wrepper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Wm. Volker Co.</u>	11. BIRTHPLACE (City and state or country) <u>Dalton, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Peter Sleyster</u>	13b. MOTHER'S MAIDEN NAME <u>Dorothy Jacobs</u>	14. NAME OF HUSBAND OR WIFE <u>Lloyd Trece</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>486-03-5234</u>	17. INFORMANT <u>Mrs. Mildred Rhodes</u> Address <u>7203 Bettyfontaine K.C. Mo.</u>
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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) <u>C.V.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
DUE TO (b) <u>Hypertension and generalized arteriosclerosis</u>		Years
DUE TO (c) <u>Diabetes mellitus, severe, and chronic glomerular nephritis.</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Osteomyelitis, right foot.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <u>6:10 a.</u> Month, Day, Year <u>March 22, 1959</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Kansas City</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>
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21. I attended the deceased from <u>March 22, 1959</u> to <u>June 14, 1959</u> and last saw her alive on <u>May 30, 1959</u> Death occurred at <u>6:10 a.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>4800 E. 24th Street</u>	22c. DATE SIGNED <u>6-16-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-17-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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24. FUNERAL DIRECTOR <u>C.H. Blackman & Son</u> ADDRESS <u>200 W. K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-16-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

R. S. Long

All diseases in Part I must be causally related.

VS
MAR 29 1960

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 *W.C. Penning*

Licensed Embalmer No. *4879*

P. O. Address *NC, Me.*

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.