

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021170

STATE FILE NUMBER

2853

FILED JUN 24 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

2853

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Platte</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>Riverside</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Lutheran</u>		Length of stay in lb. <u>45 min</u>	d. STREET (If outside, give location) ADDRESS <u>RT. 5 Bx 57</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Albert</u>			4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29 - 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Bethlehem, MO</u>
13a. FATHER'S NAME <u>Henry Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Mary K. Koontz</u>	14. NAME OF HUSBAND OR WIFE <u>Enoch Albert</u> <u>deceased 1885</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Ida Mae Scott, Riverside, MO</u>
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>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>5 years</u>
DUE TO (c) <u>hypertension essential</u>			<u>332XH</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus, adenocarcinoma uterus, hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
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 COUNTY STATE
21. I attended the deceased from <u>MAY 1, 1959</u> to <u>JUNE 8, 1959</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>JUNE 8, 1959</u> Death occurred at <u>2:26 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>S. Comer Bates, M.D.</u>		22b. ADDRESS <u>2730 SOUTH MALL, ANTIOCH CENTER, KANSAS CITY, MO</u>	22c. DATE SIGNED <u>6/10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 12 - 59</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>East Slope Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Parkville, MO</u>
24. FUNERAL DIRECTOR <u>Lehard St. Francis</u>		ADDRESS <u>Parkville</u>	25. DATE RECD. BY LOCAL REG. <u>6-12-59</u>
26. REGISTRAR'S SIGNATURE <u>neva minshall</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
G. Comer Bates

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 Haddon C. Francis, Student Embalmer No. 570

working under my personal supervision.

Student Haddon C. Francis  
Signature of Student Embalmer

Signed Haddon C. Francis  
401 Main  
Licensed Embalmer No. 3451  
P. O. Address Fairville

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.