

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021817

FILED JUN 30 1959

Registration District No. 146

Primary Registration District No. 3026

STATE FILE NUMBER

Registrar's No. 289

300
-57

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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) Independence		c. CITY OR TOWN Independence	
c. FULL NAME OF (If NOT in hospital, give location) Reiss Rest Home		d. STREET ADDRESS (If outside, give location) 1041 West Truman Rd	
3. NAME OF DECEASED (Type or print) LISSIE V. GAINES		4. DATE OF DEATH Month JUNE Day 23 Year 1959	
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 Sept. 28, 1873
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) Harrisonville, Missouri
13a. FATHER'S NAME Joseph A. Coleman		13b. MOTHER'S MAIDEN NAME Elizabeth Ann Dailey	14. NAME OF HUSBAND OR WIFE Mrs. Myra Harrington
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 Address Mrs. Myra Harrington 10605 E. 18th
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident			INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) cerebral arteriosclerosis			Years
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			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. Month, Day, Year _____			
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 _____
21. I attended the deceased from 12/24/57 to 6/23/59 and last saw her alive on 6/23/59 Death occurred at 342 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James E. Lind, M.D.		22b. ADDRESS Independence, Mo	22c. DATE SIGNED 6/25/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-25-59	23c. NAME OF CEMETERY OR CREMATORY Monument Grove	23d. LOCATION (City, town, or county) (State) Independence, Mo
24. FUNERAL DIRECTOR ADDRESS Roland P. Speaks - Indep		25. DATE RECD. BY LOCAL REG. 6-25-59	26. REGISTRAR'S SIGNATURE James E. Lind

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Rollie Fessel*

Licensed Embalmer No. *4690*
P. O. Address *Eden, W.*

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.