

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032639

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4731 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>35 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PLAZA NURSING HOME</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>4047 WARWICK BLVD.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Electa</b> Middle <b>H</b> Last <b>Ward</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>28</b> Year <b>1959</b>			
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 9 1886</b>	9. AGE (last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CLEVELAND OHIO</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>FRED HAUSERMAN</b>	13b. MOTHER'S MAIDEN NAME <b>RHINDA FULLER</b>	14. NAME OF HUSBAND OR WIFE <b>HORACE W. WARD</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>486 07 8401B</b>	17. INFORMANT Address <b>HORACE W. WARD 4047 WARWICK</b>
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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) <b>Frontal lobe Retinoblastoma Cell Sarcoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)
		DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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 <b>KANSAS CITY</b>	COUNTY <b>JACKSON</b>	STATE <b>MISSOURI</b>
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21. I attended the deceased from 1953 to Sept. 28 '59 and last saw her alive on Sept. 24 '59  
Death occurred at 1 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>A. W. Robinson MD</b>	22b. ADDRESS <b>4635 Kyandotte Kc Mo</b>	22c. DATE SIGNED <b>9-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>9 30 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K. C. MO.</b>	25. DATE RECD. BY LOCAL REG. <b>9-29-59</b>	26. REGISTRAR'S SIGNATURE <b>never minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

A. W. Robinson

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Norman W. Peterson

Licensed Embalmer No. 4889

P. O. Address 21. G. 276

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.