MO DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-032737

STATE FILE NUMBER

Registration District No. 130 Primary Registration District No. 5572 Registrar's No. 196

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Rural Prairie — Length of stay in 1b: 2 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: County Hospital — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo b. COUNTY:
c. CITY OR TOWN: St Joseph — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): State Hosp # 3 — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: agnes Middle: Last: Murry
4. DATE OF DEATH: Month: Sept Day: 4 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐ (P)
8. DATE OF BIRTH: Unknown
9. AGE (last birthday): —
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Unknown
12. CITIZEN OF WHAT COUNTRY:
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Records Jackson Co Hosp Address: Indep. Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Hypertensive Cardiovascular Disease
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 May 13 1957, to Sept 4-1959 and last saw her/him alive on Sept. 4-1959
Death occurred at 8:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Paul Wolman (Degree or title) MD
22b. ADDRESS: To Co. Hosp Independence Mo
22c. DATE SIGNED: 9-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-5-59
23c. NAME OF CEMETERY OR CREMATORY: Mt Calvary
23d. LOCATION (City, town, or county) (State): Kansas City Kan

24. FUNERAL DIRECTOR: Langsford Funeral Home ADDRESS: Lees Summit Mo
25. DATE RECD. BY LOCAL REG.: 9-4-1959
26. REGISTRAR'S SIGNATURE: N. B. Langsford

(Licensed Embalmer's Statement on Reverse Side)

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 383

P. O. Address _____

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