

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040354

FILED VS DEC 7 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5609 STATE FILE NUMBER

ENDED

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>Davis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>Coffey Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Research Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Sadler</u> Last <u></u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Hilman City, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	

13a. FATHER'S NAME <u>Tom Cutschall</u>		13b. MOTHER'S MAIDEN NAME <u>Adaline Benedick</u>		14. NAME OF HUSBAND OR WIFE <u>Earl Sadler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Virgil Sadler</u> Address <u>6000 E. 60th St Mo K.C. 19, 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>Hemorrhage, Gastric</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinomatous</u>			<u>6-12 Mo.</u>
	DUE TO (c) <u>Coccioma Pancreas</u>			<u>6-12 Mo.</u>
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		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 Nov 3, 1959 to Nov 19, 1959 and last saw her alive on Nov 19, 1959
Death occurred at Research Hospital on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert C. Mc Cleary</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>890 Professional Bldg</u>		22c. DATE SIGNED <u>11/20/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Hilman City, Mo.</u>	
24. FUNERAL DIRECTOR <u>D.W. Newcomers, M.S.C. Mo.</u>		ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>11-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Alva Minshall</u>

DOCUMENT BY AFFIDAVIT OF Robert C. Mc Cleary, M.D. MEDICAL CERTIFICATION

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 John V. Henrich, Jr.

Licensed Embalmer No. 4848

P. O. Address R. B. 17, Mo.

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.