

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8492

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1257</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Kansas City</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>Jackson</u>	
c. LENGTH OF STAY (In this place) <u>1 1/2 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>433 So. Jackson</u>		3 ✓ 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>433 So. Jackson</u>				d. STREET ADDRESS (If rural, give location) <u>433 So. Jackson</u>			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) <u>Alice</u>			b. (Middle) <u>Myrtle</u>			c. (Last) <u>Liles</u>	
(Type or Print)			4. DATE OF DEATH <u>3-16-49</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Dec. 17, 1877</u>	
9. AGE (In years last birthday) <u>71 7/8</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>15</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13a. FATHER'S NAME <u>John Waggoner</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Martha Gowie</u>			14. NAME OF HUSBAND OR WIFE <u>John Daniel Liles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Opal Hansen 433 So. Jackson</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Recurrent Carcinoma of Colon.</u>				2 yrs.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) <u>153X</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>5/14/47</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Colon</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5</u>			
22. I hereby certify that I attended the deceased from <u>May 5, 1947, to Mar 16, 1949</u> , that I last saw the deceased alive on <u>Mar 16, 1949</u> , and that death occurred at _____ A. M., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. J. Cochrane</u> (Degree or title)				23b. ADDRESS <u>M.D. 315 Blumeda Rd. Kansas City, Mo.</u>		23c. DATE SIGNED <u>3/17/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-19-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Newton Burial Park,</u>		24d. LOCATION (City, town, or county) (State) <u>Nevada, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-19-49</u>		REGISTRAR'S SIGNATURE <u>Sheldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE &amp; McCLURE</u>		ADDRESS <u>Kansas City, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Wm. Cookrane

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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.

Signed \_\_\_\_\_

*Ralmer H Reed*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3245

P. O. Address K. E. M.

**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 this body is not embalmed, fact should be so stated above.