

23767

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 16 1949

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 194

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, write RURAL and give township) OR TOWN INDEPENDENCE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN INDEPENDENCE,	
c. LENGTH OF STAY (in this place) 13		d. STREET ADDRESS (If rural, give location) KINGSHIGHWAY	
d. FULL NAME OF HOSPITAL OR INSTITUTION RESIDENCE : KINGSHIGHWAY			

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle) K.	c. (Last) SOPER.	4. DATE OF DEATH (Month) (Day) (Year) JULY 1 1949
-------------------------------------	------------------------	-----------------------	-------------------------	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED/	8. DATE OF BIRTH MAY 1, 1865	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	---	-------------------------------------	---	------------------------	----------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY STEAM ENGINEER	11. BIRTHPLACE (State or foreign country) TORONTO ; CANADA 2	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	---	---	--

13a. FATHER'S NAME SAMUEL SOPER.	13b. MOTHER'S MAIDEN NAME AMY JANE HOWELL	14. NAME OF HUSBAND OR WIFE ALETHA SOPER
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ALETHA SOPER ADDRESS KINGSHIGHWAY INDEP. MO.
--	-----------------------------------	--

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension, arteriosclerosis DUE TO (c) Cerebral sclerosis.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from May 5, 1949, to 7-1, 1949, that I last saw the deceased alive on 6-30, 1949, and that death occurred at 9 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George M. Park M.D.	23b. ADDRESS 11037 W. Maple Rd. Independence Mo.	23c. DATE SIGNED 7-1-49
---	---	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 5, 1949	24c. NAME OF CEMETERY OR CREMATORY MOULD GROVE	24d. LOCATION (City, town, or county) (State) INDEPENDENCE JACKSON MO.
---	-------------------------------	---	---

DATE REC'D BY LOCAL REG. B-2-49	REGISTRAR'S SIGNATURE [Signature]	354 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 815 W. MAPLE, INDEP. MO.
--	--	---

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

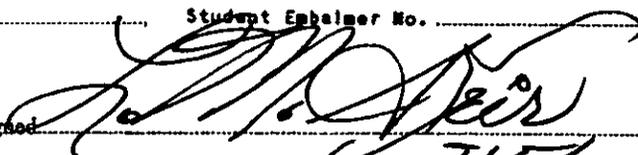
RECEIVED JUL 13 RECD
Jackson County Health Dept,
County File Number _____
Date Filed _____

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 _____

working under my personal supervision.

Student
Student Embalmer

Signed  _____

Student Embalmer No. _____

Licensed Embalmer No. 3156

P. O. Address *Indep. 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 this body is not embalmed, fact should be so stated above.