

FILED AUG 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22989**

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **3111**

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 Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 4410 Wornall	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) E. c. (Last) Corder			4. DATE OF DEATH (Month) (Day) (Year) 7 - 21 - 1951		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug. 20, 1878	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME James R. Chambers		13b. MOTHER'S MAIDEN NAME Susan Greover		14. NAME OF HUSBAND OR WIFE Thad P. Corder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Arthur Schulz 643 W. 59th.	

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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 8 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) unknown		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			5-2-21

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)		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 **7 - 13**, 19 **51**, to **7 - 21**, 19 **51**, that I last saw the deceased alive on **7 - 21**, 1951, and that death occurred at **7:00A** m., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns M D O (Degree or title)			23b. ADDRESS Med. Dir. General Hospital No. 1		23c. DATE SIGNED 7-21-51
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-23-51	24c. NAME OF CEMETERY OR CREMATORY Corder		24d. LOCATION (City, town, or county) (State) Cooker MO.

DATE REC'D BY LOCAL REG. 7-22-51		REGISTRAR'S SIGNATURE Heraldine Palmest		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Forest of Hope Higginsville, MO.	
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(Licensed Embalmer's Statement on Reverse Side)

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

10-2-1907

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
Student Embalmer

Signed *Forrest A. Hooper*

Licensed Embalmer No. *4358*

P. O. Address *Higginsville, 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.