

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4759**
539
Registrar's No.

FILED FEB 18 1954

BIRTH MO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>539</u>		
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE <u>MISSOURI</u> c. COUNTY <u>JACKSON</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>30 yrs</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2941-BRIGHTON</u>				e. STREET ADDRESS (If rural, give location) <u>25 2941 BRIGHTON</u> <u>3350</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>NELLIE</u> b. (Middle) <u>M.</u> c. (Last) <u>CADE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-1-54</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>5-6-1902</u>		
9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>DES MOINES IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>SHEPLER V. FRYE</u>			13b. MOTHER'S MAIDEN NAME <u>MINNIE HEMMINGWAY</u>		14. NAME OF HUSBAND OR WIFE <u>LEONARD O. CADE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Leonard O. Cade, 2941 Brighton</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Liver (Degeneration & Portal Hypertension)</u> DUE TO (c) <u>Arteriosclerosis & Atherosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Tubercular Hemiparesis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 Minutes</u> <u>4 years</u> <u>6 months</u> <u>3 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____ <u>5810</u>						
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) (Min.) _____		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 <u>Aug 1, 1952</u> to <u>Feb 1, 1954</u> , that I last saw the deceased alive on <u>Feb 1, 1954</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE Wm. W. THOMPSON (Degree or title) _____			23b. ADDRESS <u>6218 Prospect, N.C. Mo</u>			23c. DATE SIGNED <u>2-1-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>2-4-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>FORT SCOTT KANSAS</u>		
DATE REC'D BY LOCAL REG. <u>2-3-54</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Tom P. Stewart, N.C. Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

W. Leary
Proctor

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 P. Smith*

Licensed Embalmer No. *362*

P. O. Address *R. C. W.*

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.