

FILED MAR 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4705

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 627

1. PLACE OF DEATH a. COUNTY <u>Jacks on</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>15 yrs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital # 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Marian</u>		b. (Middle) <u>E</u>	
		c. (Last) <u>Cooper</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>June 18-1918</u>	
9. AGE (in years last birthday) <u>36</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Chillicothe Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Aaron Albright</u>		13b. MOTHER'S MAIDEN NAME <u>Floretta Bigelow</u>	
14. NAME OF HUSBAND OR WIFE <u>Densie Cooper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Densie Cooper</u>		ADDRESS <u>2939 Michigan</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>Atelectasis and bilateral hydrothorax;</u> ANTECEDENT CAUSES <u>uremia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>carcinoma of the cervix with metastases</u> DUE TO (c) _____ 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)		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>Feb. 10</u> , 19 <u>55</u> , to <u>Feb. 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>55</u> , and that death occurred at <u>2:35 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>B.I. Burns</u> (Degree or title)		23b. ADDRESS <u>24th & Cherry Sts.</u>	
23c. DATE SIGNED <u>2/14/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb-15-55</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Chillicothe Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-15-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wilks Funeral Home</u>		ADDRESS <u>N.C. MO</u>	

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

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 *Chas E Wilks*

Licensed Embalmer No. *26*

P. O. Address *Kern*

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.