

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

135007

STATE FILE NUMBER

FILED APR 16 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1474

Health,
& Welfare
Public
Service

S. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Length of stay in 19 63 4	d. STREET ADDRESS (If outside, give location) 6414 Independence Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MATTIE Middle A Last WYNN			4. DATE OF DEATH Month March Day 27 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1892
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Private Home	11. BIRTHPLACE (City and state or country) Nebraska
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Warren Cooley	
14. MOTHER'S MAIDEN NAME No Record		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 Carl L Wynn 5809 Appleton Raytown Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Hypertensive Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) thrombosis of aorta near its bifurcation			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 44 lbs
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) road	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Raytown Mo	
20g. COUNTY Missouri		20h. STATE Missouri	
21. I attended the deceased from 12 Feb 1955 to 27 Feb 1957 and last saw her alive on 27 Feb 57 Death occurred at 4:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Jack M Davis M.D. (Degree or title)		22b. ADDRESS Raytown Mo	22c. DATE SIGNED 28 Feb 57
23a. BURIAL INFORMATION, REMOVAL (Specify) Burial	23b. DATE 3/29/57	23c. NAME OF CEMETERY OR CREMATORY Mt Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo		25. DATE RECD. BY LOCAL REG. 3-29-57	26. REGISTRAR'S SIGNATURE Mrs Minshall

Jack M. Davis

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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.

Student
Signature of Student Embalmer

Signed *James A. Smith*

Licensed Embalmer No. *495*

P. O. Address *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.