

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13560

STATE FILE NUMBER

FILED APR 25 1957

Registration District No. 146 Primary Registration District No. 5570 Registrar's No. 168

S. 300
7. 1-56

securing the medical certification in the specific manner required by 193.140, R.S.Mo. 1947.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually 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 Ft. Osage Twp. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Sibley Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt. 1, Buckner Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 7000 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JENNIE LEE COMPTON First Middle Last			4. DATE OF DEATH Apr. 13, 1957 Month Day Year
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 Jan. 14, 1886
9. AGE (In years by birthday) 75		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (City and state or country) Jackson Co., Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jas. B. Strange	
14. MOTHER'S MAIDEN NAME Laura Tucker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Earle Kolle, Rt. 1, Buckner, Mo. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Septicemia Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Overweight DUE TO (c) Overweight			INTERVAL BETWEEN ONSET AND DEATH 4 hr 7 yrs 7 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331x			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.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from April 6, 1957 to April 13, 1957 her last saw him alive on April 12, 1957 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 (Degree or title) W. Allen M.D.		22b. ADDRESS Independence, Mo.	
22c. DATE SIGNED 4/15/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Apr. 16, 1957	
23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION (City, town, or county) (State) Jackson Co., Missouri	
24. FUNERAL DIRECTOR ADDRESS George C. Carson, Independence, Mo.		25. DATE RECD. BY LOCAL REG. 4-16-57	
26. REGISTRAR'S SIGNATURE [Signature]			

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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 *Tom D. Marbland*.....

Licensed Embalmer No. *459*

P. O. Address *Indep Y*.....

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.