

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001267

STATE FILE NUMBER

13

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registration No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5804 Grand</b>		d. STREET ADDRESS (If outside, give location) <b>4010 Bell</b>	
Length of stay in 1b <b>45 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lina</b> Middle <b>DeGrofft</b> Last <b>DeGrofft</b>			4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1874</b>
9. AGE (In years) <b>87 8/8</b>		FUNDER 1 YEAR Months <b>8</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b>8</b> Min. <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>Meigs County, Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Thomas Pilchard</b>	
13b. MOTHER'S MAIDEN NAME <b>Rebecca</b>		14. NAME OF HUSBAND OR WIFE <b>John DeGrofft</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Frank Seifert 1432 East 67th K.C. Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene - right foot and leg.</b> Conditions, if any, which gave rise to above cause (a), storing the underlying cause last. } DUE TO (b) <b>Thrombosis - right femoral artery</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>Leukemia, Chronic lymphatic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b>
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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>Dec 1, 1958</b> to <b>Jan 1, 1959</b> and last saw her alive on <b>12/31/58</b> Death occurred at <b>12:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Edward H. Klein M.D.</b>		22b. ADDRESS <b>Class Med. Bldg-KC-12-Mo/2/59</b>	
22c. DATE SIGNED <b>1-4-59</b>		22d. _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 3. 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons</b>		ADDRESS <b>Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-4-59</b>
26. REGISTRAR'S SIGNATURE <b>new marshall</b>			

(Licensed Embalmer's Statement on Reverse Side)

Occur, however, etc. must use only standard nomenclature in them to no symptoms with or without.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Edward H. Klein

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 *Norman W. Larson* .....

Licensed Embalmer No. *4889* .....

P. O. Address. *St. Louis, 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.