

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005941
STATE FILE NUMBER

FILED FEB 19 1959 Station District No. 149 Primary Registration District No. 1002 Registrar's No. 711

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>22 Cypress</u>		Length of stay in lbs <u>63 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>122 Cypress</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) LELR MAY VOGAN
First Middle Last
4. DATE OF DEATH 2-5-1959
Month Day Year

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED NEVER MARRIED
WIDOWED DIVORCED 8. DATE OF BIRTH SEPT. 30-1895 9. AGE (In years (Last birthday) 63
IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (If not at work done at home) SPONSOR 10b. KIND OF BUSINESS OR INDUSTRY MONTGOMERY WARD 11. BIRTHPLACE (City and state or country) K.C., MISSOURI 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME CHARLES F. MILLER 13b. MOTHER'S MAIDEN NAME HATTIE NICOLAI 14. NAME OF HUSBAND OR WIFE LEO VOGAN

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. LEO VOGAN 17. INFORMANT LEO VOGAN
Address 122 CYPRESS K.C., 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) Respiratory Failure INTERVAL BETWEEN ONSET AND DEATH 3 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Generalized Carcinoma 5 months
DUE TO (c) CA left Ovary Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Jan 12th 1958 to Feb 5-59 and last saw her alive on Feb 4th 1959
Death occurred at 10:45 AM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W.M. Fowler Do. 22b. ADDRESS Wirthman Bldg. K.C. Mo 22c. DATE SIGNED 2-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 2-9-1959 23c. NAME OF CEMETERY OR CREMATORY W. Washington Cem. 23d. LOCATION (City, town, or county) (State) Kansas City Mo.

24. FUNERAL DIRECTOR ADDRESS C.H. Blackman & Son?m. K.C. Mo 25. DATE RECD. BY LOCAL REG. 2.6.59 26. REGISTRAR'S SIGNATURE Neva Marshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. M. Fowler

MEDICAL CERTIFICATION

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 *Best B. Bennett*

Licensed Embalmer No. *4656*
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.