

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025095

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3342 STATE FILE NUMBER

FILED JUL 28 1961

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) <u>Kansas City</u>		Length of stay in 1b <u>3 years</u>	c. CITY OR TOWN <u>Kansas City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Walnut Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>325 Olive</u>
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>COBLE</u> Last <u>COBLE</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1961</u>	

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 1884</u>	9. AGE AT DEATH IF UNDER 1 YEAR: Months <u>79</u> Days <u>07</u> IF UNDER 24 HR: Hours <u>00</u> Min. <u>00</u>
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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	11. BIRTHPLACE (City and state of country) <u>Cass Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Robert Taylor Norton</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia N Pugh</u>	14. NAME OF HUSBAND OR WIFE <u>George W Coble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mr. Mary Probst 405 W. Madison Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, Generalized</u>	
DUE TO (c) <u>Senility</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile Dementia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 July 1958 to July 61 and last saw her alive on 30 June 61  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Stallan H. Graham M.D.</u>	22b. ADDRESS <u>518 Argyle Bldg HO, Mo</u>	22c. DATE SIGNED <u>5 July 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 8 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>
24. FUNERAL DIRECTOR <u>Rennenburg Harrisonville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-5-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
BY AFFIDAVIT OF  
WELFARE H. GIBBINS  
MEDICAL CERTIFICATION  
ITEM NO. SHOULD READ

**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

*Ernest Remminger*

Licensed Embalmer No.

*3368*

P. O. Address

*Harrisonville*

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.