

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5000 - 61-036849
STATE FILE NUMBER

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

FILED OCT 19 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	Jackson	a. STATE	Missouri b. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	Kansas City	c. CITY OR TOWN	Kansas City
Length of stay in 1b	30 yrs.	Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	St. Mary's Hospital	d. STREET ADDRESS (If outside, give location)	3012 DeGroff Way
Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Lula	Middle May	Last Cooper	4. DATE OF DEATH	Month October	Day 8,	Year 1961
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5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
Female	White		Mar. 8, 1877	84	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
At Home		Missouri	U. S. A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James Shipley	Mandy Gates	Oscar G. Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Kansas City, Patricia Cooper, 3012 DeGroff Way, Mo

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
IMMEDIATE CAUSE (a)	<u>Congestive Heart Failure</u>	<u>2 + Wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>	<u>5+ years</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	s.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
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21. I attended the deceased from 10/6/61 to 10/8/61 and last saw her alive on 10/7/61.
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)	22b. ADDRESS	22c. DATE SIGNED
<u>Mary C. Colglazier, MD</u>	<u>3317 E 43rd K.C. Mo.</u>	<u>10-9-61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>removal</u>	<u>10-9-61</u>	<u>Plainview Cem.</u>	<u>Chula, Missouri</u>

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>Stine & McClure, Kansas City, Mo.</u>	<u>10-9-61</u>	<u>Ruth Long</u>

DATE AMENDED
INSTEAD OF
DOCUMENT
BY AFFIDAVIT OF
ITEM NO. SHOULD READ
MAY C. COLGLAZIER
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 Eugene L. Harmon

Licensed Embalmer No. 4633

P. O. Address R. E. 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.