

FILED FEB 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5262**

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 13

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, write RURAL and give township) <u>Prarie Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City Mo</u>	
c. LENGTH OF STAY (in this place) <u>2 years</u>		d. STREET ADDRESS (If rural, give location) <u>34th + Warwick Blvd</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jackson County Emergency</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Leta</u>		b. (Middle) <u>Nelie</u>	
		c. (Last) <u>Tobey</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>1 23 1949</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-6-1872</u>
9. AGE (In years last birthday) <u>76</u>		10. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	11. BIRTHPLACE (State or foreign country) <u>Nebraska, Beatons</u>
10a. USUAL OCCUPATION (Give kind of work dominating most of working life, even if retired) <u>Dressmaker</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Edwards</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Mayfield</u>	
14. NAME OF HUSBAND OR WIFE <u>Frank Tobey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Loy P. Steves</u>		ADDRESS <u>Patland, Oregon</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Cholodoclitiasis</u>		<u>years</u>	
DUE TO (b) <u>Suppurative abscess gall bladder 18 yrs.</u>		<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Old fracture Rt hip</u>		<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Cholodoclitiasis</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Frank E. Trehanne MD</u>		23b. ADDRESS <u>Independence, Mo</u>	
23c. DATE SIGNED <u>1-24-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-27-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, MO</u>	
DATE REC'D BY LOCAL REG. <u>1-26-49</u>		REGISTRAR'S SIGNATURE <u>Donald C. Emshour</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>France Warnall</u>		ADDRESS <u>74 KC MO</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed Russell N France

Licensed Embalmer No. 4255

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 this body is not embalmed, fact should be so stated above.