

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30159**
3618

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
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 OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>40 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		L34		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4308 GARFIELD</u>				d. STREET ADDRESS (If rural, give location) <u>4308 GARFIELD</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSA</u>			b. (Middle) <u>ANN</u>		c. (Last) <u>COCKRIEL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 22, 1949</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>JAN. 4, 1902</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days	IF UNDER 1 Wks. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISSIONARY</u>		11. BIRTHPLACE (State or foreign country) <u>CLARKSTOWN, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>CLEMINGS</u>		13b. MOTHER'S MAIDEN NAME <u>Susan G. Dodson</u>		14. NAME OF HUSBAND OR WIFE <u>Anderson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Fred R. Covert</u> ADDRESS <u>2436 E. 9th St. Kansas City</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Cardiac Failure</u> ANTECEDENT CAUSES <u>Chronic Cardiac dilatation with hcc compensation</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>1 mo</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) _____		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 <u>July 22, 1949</u> , to <u>Aug 22, 1949</u> , that I last saw the deceased alive on <u>Aug 20, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>F. C. Lamar, M.D.</u>			23b. ADDRESS <u>624 Prof Bldg</u>			23c. DATE SIGNED <u>Aug 22 '49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Aug 24-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ELMWOOD CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO</u>		
DATE REC'D BY LOCAL REG. <u>8-23-49</u>		REGISTRAR'S SIGNATURE <u>Doraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. Newcomer</u> ADDRESS <u>Southern K.C. Mo</u>				

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

624 Photo-1009

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 *Bernard L. Goran*

Licensed Embalmer No. *4250*

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.