

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31749  
4635

State File No. \_\_\_\_\_

FILED OCT 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u> |  |
| b. CITY OR TOWN <u>Kansas City</u>                               |  | c. CITY OR TOWN <u>Overland Park 9150</u>   |  |
| c. LENGTH OF STAY (in this place) <u>6 Mo</u>                    |  | d. STREET ADDRESS (If rural, give location) <u>6503 West 77<sup>th</sup> Terrace</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u> |  |   |  |

|  |                     |                      |                        |   |
|--|---------------------|----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) <u>Mabel</u> | a. (First) <u>M</u> | b. (Middle) <u>K</u> | c. (Last) <u>Coons</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 24 53</u> |
|--|---------------------|----------------------|------------------------|---|

|                      |                               |   |                                      |  |                               |                              |
|----------------------|-------------------------------|---|--------------------------------------|--|-------------------------------|------------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u> | 8. DATE OF BIRTH <u>Feb 12, 1889</u> | 9. AGE (In years) (Last birth/day) <u>64</u> | IF UNDER 1 YEAR Months   Days | IF UNDER 4 HRS. Hours   Min. |
|----------------------|-------------------------------|---|--------------------------------------|--|-------------------------------|------------------------------|

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sole Lady</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> | 11. BIRTHPLACE (State or foreign country) <u>Olathe Kansas</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
|--|--|--|--|

|  |   |   |
|--|---|---|
| 13a. FATHER'S NAME <u>James Cromwell</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Hamilton</u> | 14. NAME OF HUSBAND OR WIFE <u>P.O. Coons</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>526-341-209</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Frank E. Bair</u> ADDRESS <u>6503 West 77<sup>th</sup> Terrace Overland Park, Mo.</u> |
|--|--|--|

|  |   |            |                                  |
|--|---|------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |            | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL METASTASIS</u>   |            | <u>2 WKS.</u>                    |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>CARCINOMA OF RT BREAST</u><br>DUE TO (c) |            | <u>3 YRS</u>                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |   | <u>NOX</u> |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) m. | 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 1/5, 1950, to 9/24, 1953, that I last saw the deceased alive on 9/24, 1953, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

|   |                                      |                                 |
|---|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>John W. Walker MD</u> (Degree or title) | 23b. ADDRESS <u>Kansas City, Mo.</u> | 23c. DATE SIGNED <u>9/24/53</u> |
|---|--------------------------------------|---------------------------------|

|  |                               |   |  |
|--|-------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>Sept 26 1953</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Olathe Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Olathe Kansas</u> |
|--|-------------------------------|---|--|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG. <u>9-26-53</u> | REGISTRAR'S SIGNATURE <u>Heraldine Smith</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H.E. Julien</u> ADDRESS <u>Olathe Mo.</u> |
|---|--|---|

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

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Chester L. Fleming*

Signed.....  
Student Embalmer

Licensed Embalmer No. *1569*

P. O. Address *Olathe Kan.*

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.