

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42828**

FILED JAN 14 1954

Registrar's No. **6000**

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 6000	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 31 YEARS		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		3438	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vineyard Hospital				d. STREET ADDRESS (If rural, give location) 112 VINEYARD PARK HOSPITAL			
3. NAME OF DECEASED a. (First) EMMA		b. (Middle) H		c. (Last) COOK		4. DATE OF DEATH (Month) (Day) (Year) 12 22 53	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2		8. DATE OF BIRTH (Last birthday) (Month) (Day) (Year) DEC. 18-1872 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY LIBRARIAN		11. BIRTHPLACE (City and State or Foreign Country) ST. JOSEPH MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME JACOB HECKEL			13b. MOTHER'S MAIDEN NAME CHRISTINE ADLER			14. NAME OF HUSBAND OR WIFE UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME MISS MARIE HECKEL			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalo-Malaria ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Senility				INTERVAL BETWEEN ONSET AND DEATH 1 mo 1 yr 332X	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 16, 1951 to Dec 22, 1953 that I last saw the deceased alive on Dec 21, 1953 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE J.G. Sheldon				23b. ADDRESS 254 Gibson Rd		23c. DATE SIGNED 12-22-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		24b. DATE DEC. 23-1953		24c. NAME OF CEMETERY OR CREMATORY D.W. NEWCOMER'S SONS		24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
DATE REC'D BY LOCAL REG. 12-23-53		REGISTRAR'S SIGNATURE Sheraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE D.W. Newcomer Sons			
				ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.			

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. _____

Student
Student Embalmer

Signed *Robert J. Boyer*

Licensed Embalmer No. *4892*

P. O. Address *K.C. 10, 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.