

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8784**

BIRTH NO. FILED MAR 31 1954 REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1092**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>  |  | c. CITY OR TOWN <b>KANSAS CITY</b>  |  |
| c. LENGTH OF STAY (In this place) <b>5 YEARS</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>           |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b> |  | e. STREET ADDRESS (If rural, give location) <b>600 WEST 85<sup>th</sup> STREET</b>  |  |

|                                     |                          |                       |                                       |  |  |
|-------------------------------------|--------------------------|-----------------------|---------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or Print) |                          |                       | 4. DATE OF DEATH (Month) (Day) (Year) |  |  |
| a. (First) <b>MARIE</b>             | b. (Middle) <b>VELMA</b> | c. (Last) <b>LONG</b> | <b>MARCH-9-1954</b>                   |  |  |

|                      |                               |  |  |   |                        |                      |       |      |
|----------------------|-------------------------------|--|--|---|------------------------|----------------------|-------|------|
| 5. SEX <b>FEMALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED 3</b> | 8. DATE OF BIRTH <b>SEPT. 27, 1876</b> | 9. AGE (In years last birthday) <b>77</b> | If UNDER 1 YEAR Months | If UNDER 4 WKS. Days | Hours | Min. |
|----------------------|-------------------------------|--|--|---|------------------------|----------------------|-------|------|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <b>WINDSOR, MISSOURI, D</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|--|-----------------------------------|--|---|

|  |  |                             |
|--|--|-----------------------------|
| 13a. FATHER'S NAME <b>SYLVESTER COTTEN</b> | 13b. MOTHER'S MAIDEN NAME <b>MARY ANN BURRUS</b> | 14. NAME OF HUSBAND OR WIFE |
|--|--|-----------------------------|

|   |                                     |  |
|---|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> | 16. SOCIAL SECURITY NO. <b>NONE</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>MRS. M. LEONE LONG</b> ADDRESS <b>600 WEST 85<sup>th</sup> ST. KANSAS CITY, MO.</b> |
|---|-------------------------------------|--|

|   |  |  |                                  |
|---|--|--|----------------------------------|
| 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, asphyxia, 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) <b>Cerebral Hemorrhage</b>  |  | <b>10 days</b>                   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Left Hemiplegia &amp; aphasia</b><br><b>Coma</b><br>DUE TO (c) <b>Arteriosclerosis &amp; Hypertension</b> |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic Auricular Fibrillation</b><br><b>Terminal Myocardial Failure</b>                 |  |  |                                  |

|                                    |  |  |
|------------------------------------|--|--|
| 19a. DATE OF OPERATION <b>none</b> | 19b. MAJOR FINDINGS OF OPERATION <b>none</b> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>none</b> |
|--|--|---|

|   |  |  |
|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>none</b> |
|---|--|--|

22. I hereby certify that I attended the deceased from **Feb 27, 1954**, to **March 8, 1954**, that I last saw the deceased alive on **Mar 8, 1954**, and that death occurred at **1:30 p. m.**, from the causes and on the date stated above.

|   |   |                                |
|---|---|--------------------------------|
| 23a. SIGNATURE <b>J. Harvey Jenett</b> (Degree or title) <b>J. Harvey Jenett M.D.</b> | 23b. ADDRESS <b>424 Professional Bldg. Kansas City Mo</b> | 23c. DATE SIGNED <b>3-9-54</b> |
|---|---|--------------------------------|

|   |                              |   |   |
|---|------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 24b. DATE <b>MAR-11-1954</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b> | 24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b> |
|---|------------------------------|---|---|

|   |  |   |
|---|--|---|
| DATE REC'D BY LOCAL REG. <b>3-11-54</b> | REGISTRAR'S SIGNATURE <b>Geraldine Smith</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>W. N. Newcombs</b> ADDRESS <b>1231 BRUSH CREEK BYD. KANSAS CITY, MISSOURI</b> |
|---|--|---|

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Kellie Kessel*

Licensed Embalmer No...46...

P. O. Address...K.C.V...

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.