

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **4998**  
**854**

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>149</u>  |   | PRIMARY REG. DIST. NO. <u>1002</u>  |  | 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>Mo</u> b. COUNTY <u>JACKSON</u>   |  |  |  |   |  |
| b. CITY OR TOWN <u>Kansas City</u>  |  | c. LENGTH OF STAY (in this place) <u>34 YEARS</u>  |   | c. CITY OR TOWN <u>Kansas City</u>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Med. Center</u>  |  |  |   | STREET ADDRESS (If rural, give location) <u>1180 3678 Jefferson STREET</u>  |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Lillie</u>   |  |  | b. (Middle) <u>Behle</u>                          |   | c. (Last) <u>Ocheltree</u>   |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>2 22 55</u> |   |  |
| 5. SEX <u>W F</u>   |  | 6. COLOR OR RACE <u>W</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>   |  | 8. DATE OF BIRTH <u>FEB 1, 1868</u>  |  | 9. AGE (In years last birthday) <u>97</u>             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>  |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Coffeyville, Mississippi</u> |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>            |  |
| 13a. FATHER'S NAME <u>HENRY A Tabor</u>   |  |  | 13b. MOTHER'S MAIDEN NAME <u>MARY JANE Dodson</u> |   |  | 14. NAME OF HUSBAND OR WIFE <u>REV. CHARLES H. Ocheltree</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>NONE</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>MRS LEONARD M. GILLMAN</u> ADDRESS <u>4951 FAIRWAY ROAD</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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Coronary Occlusion</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma Cecum</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><u>4201 H</u> |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |   |   |  | 20. AUTOPSY?<br>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 _____, 19 <u>57</u> , to <u>2-22-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-21-</u> , 19 <u>55</u> , and that death occurred at <u>8:25 a.m.</u> , from the causes and on the date stated above. |  |  |   |   |  |  |  |   |  |
| 23a. SIGNATURE <u>E. J. Petry M.D.</u>  |  |  |   | 23b. ADDRESS <u>701 E 63rd St. Nemo</u>   |  | 23c. DATE SIGNED <u>2-22-55</u>  |  |   |  |
| 24a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>   |  | 24b. DATE <u>FEB 24, 1955</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>HUME Cemetery</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>HUME, Missouri</u>  |  |   |  |
| DATE REC'D BY LOCAL REG. <u>2-24-55</u>   |  | REGISTRAR'S SIGNATURE <u>Neva Marshall</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. Newcomb's Sons</u> ADDRESS <u>BRUSH CREEK Blvd K.C. 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.....  
Signature of Student Embalmer

Signed *Albert F. Savage*

Licensed Embalmer No. *481*

P. O. Address *Genoa*

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.