

FILED NOV 23 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36983**
4836

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4836</u>	
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 (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>30 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4639 Genesee</u>				STREET ADDRESS (If rural, give location) <u>4639 Genesee</u> <u>37150</u>			
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Elizabeth Clara</u> b. (Middle) <u>Rapier</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 8, 1955</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>3-27-1859</u>	
9. AGE (In years last birthday) <u>96</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
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>home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Rockford, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Moelendoff Goodwin</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jane Taylor</u>			14. NAME OF HUSBAND OR WIFE <u>Darius Perrin Rapier</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Miss Wanda Rapier, Kansas City, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Serility</u> DUE TO (c) <u>Arterio-Sclerosis Generalized</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>10 yrs</u> <u>15 yrs</u> <u>4201</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)		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>June 19, 54</u> to <u>Nov 9, 1955</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Don Carlos Teate</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>1500 Prof. Bldg</u>		23c. DATE SIGNED <u>11-9-55</u>	
24a. BURIAL CREMATION (REMOVAL) (Specify) <u>burial</u>		24b. DATE <u>11-11-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>11-9-55</u>		REGISTRAR'S SIGNATURE <u>Neva Minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gates Funeral Home, Kansas City, Kans.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

V1
Prof
Dr.

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 *Joseph M. M. Carthy*

Licensed Embalmer No. 469

P. O. Address *K. E. M.*

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.