

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24674

STATE FILE NUMBER  
3335

FILED AUG 12 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3335

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-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>TOWN Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>Manor Nursing Home</b>			Length of stay in lb <b>40 yrs</b>		4. STREET ADDRESS (If outside, give location) <b>730 Bennington</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>HENRIETTA</b> Last <b>LANPHERE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4 1882</b>		9. AGE (In years last birthday) <b>75</b>	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) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Opt Store Jones Store</b>		11. BIRTHPLACE (City and state or country) <b>Holden Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Erval Affeld</b>			13b. MOTHER'S MAIDEN NAME <b>UNK</b>		14. NAME OF HUSBAND OR WIFE <b>George J Lanphere</b>		
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>486-09-8242</b>		17. INFORMANT Address <b>Mr George Lanphere 730 Bennington K C Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>METASTATIC CARCINOMA LIVER</b>						<b>6 MOS.</b>	
DUE TO (c) <b>ADENOCARCINOMA COLON 153X</b>						<b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>5/5/57</b> to <b>7/15/57</b> and last saw her alive on <b>7/15/57</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>George K. Landis, M.D.</b> (Degree or title)				22b. ADDRESS <b>1630 Prof. Bldg.</b>		22c. DATE SIGNED <b>7/17/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>July 18 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wamego Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Wamego Kansas</b>	
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b>				25. DATE RECD. BY LOCAL REG. <b>7-17-57</b>		26. REGISTRAR'S SIGNATURE <b>Norm Minshall</b>	

MEDICAL CERTIFICATION  
George K. Landis USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Thomas A. Shel* .....

Licensed Embalmer No. *4954* .....  
P. O. Address. *K.C. Mo.* .....

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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.