

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28376

STATE FILE NUMBER

FILED AUG 30 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3796

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Leo F. Cooper

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, give TOWNSHIP only) OR TOWN <u>3508 Flora Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3508 Flora</u>		Length of stay in 154 <u>35 yrs</u>	d. STREET ADDRESS <u>3508 Flora</u>		Reside on Farm <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>V.</u> Last <u>Toelle</u>			4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>9-2-1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>10</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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Paola, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>David Raney</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Williams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <u>Lester A. Smith- Kansas City, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____ DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <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 _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>August 6, 1957</u> to <u>8-12-57</u> and last saw her alive on <u>8-10-57</u> Death occurred at <u>7:30</u> p. m. on the date stated above; and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE <u>Leo F. Cooper M.D.</u>			(Degree or title)	22b. ADDRESS <u>1220 E. 31st K.C. Mo</u>	22c. DATE SIGNED <u>8-12-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Paola Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Paola Kansas</u>	
24. FUNERAL DIRECTOR <u>Freeman Mortuary, Kansas City, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-13-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

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SEP 18 1957

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 *Clayton H. Barnes*

Licensed Embalmer No. 47

P. O. Address *701*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.