

FILED OCT 9 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4362

300  
1-57

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) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) <u>Leland Hospital</u>		Length of stay in lb <u>35 yo.</u>		d. STREET ADDRESS (If outside, give location) <u>1410 Asken</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>ALICE</u> Last <u>SCOTT</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-15-1884</u>		9. AGE (In years, months, days) <u>73</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</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 country) <u>Koshkonong, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph M. Howell</u>		13b. MOTHER'S MAIDEN NAME <u>Susan V. Guthrie</u>		14. NAME OF HUSBAND OR WIFE <u>James E. Scott</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>-</u>		17. INFORMANT <u>Mrs. Eva M. Wright</u>		Address <u>414 N. Kensington K.C. 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>HYPSTATIC PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>72 HRS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>FRACTURED LEFT HIP AT HOME</u>						<u>3 WKS.</u>	
DUE TO (c) <u>ARTHRITIS</u>						<u>59030</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" 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.) <u>fell on floor</u>					
20c. TIME OF INJURY Hour a.m. p.m. <u>8-22-57</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		COUNTY <u>Jackson</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>1955</u> to <u>9-18-1957</u> and last saw her alive on <u>9-18-1957</u> . Death occurred at <u>Leland Hospital 9-18-1957</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Ed Church Sr</u> (Degree or title)				22b. ADDRESS <u>Grandview Mo</u>		22c. DATE SIGNED <u>9-19-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept-21-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shoal Hills Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
24. FUNERAL DIRECTOR <u>C. H. Blackman &amp; Son Inc.</u> ADDRESS <u>K.C. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-19-57</u>		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>		

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.



do 1-5515

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 *W.C. Rivine* .....

Licensed Embalmer No. *4879* .....  
P. O. Address *T.P. Mo* .....

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.