

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35830  
STATE FILE NUMBER

FILED NOV 1 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4703

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>	
b. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Parkville - Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Cross Nursing Home</u> Length of stay in 1b <u>4 da</u>		d. STREET ADDRESS <u>800 Main St</u> (If outside, give location) <u>0856</u> Side on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Dora</u> Middle <u>(None)</u> Last <u>Graden</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>8.</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 checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 - 1877</u>
9. AGE (In years <u>80</u> (If birthday) <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> )		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Parkville Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13a. FATHER'S NAME <u>Samuel Graden</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Samples</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>G. J. Breen</u> Address <u>Parkville 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>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Fracture of Right Hip - June 1957 - Carcinoma Sigmoid Colon - Resection 1957</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4201H</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" 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 <u>1942</u> to <u>Oct 8 '57</u> and last saw her alive on <u>Oct 8 1957</u> Death occurred at <u>2:40 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Carl R. Ferris</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>535 Angyle Bldg</u> <u>Kansas City Mo</u> DATE SIGNED <u>Oct 10, 1957</u>	
23a. BURIAL, CREMATION, (REMOVED) (Specify) <u>burial</u>	23b. DATE <u>Oct 11-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Parkville Mo</u>
24. FUNERAL DIRECTOR <u>Leland H. Francis</u> ADDRESS <u>Parkville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-11-57</u>	
26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION



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 Leland G. Francis

Licensed Embalmer No. 3451  
P. O. Address Parkville

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.