

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40279  
STATE FILE NUMBER  
5520

FILED DEC 11 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300  
v. 1-57

3

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) OR TOWN <b>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) HOSPITAL OR INSTITUTION <b>DEADON ARRIVAL ST. JOSEPH HOSPITAL</b>		Length of stay in 1b <b>32 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>7103 WABASH AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>THEODORE</b> Last <b>COVER</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>20</b> Year <b>1957</b>			
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5. SEX <b>MALE</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>JAN. 22 - 1892</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER DEALER'S SERVICE</b>	11. BIRTHPLACE (City and state or country) <b>BETHANY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>JAMES W. COVER</b>	13b. MOTHER'S MAIDEN NAME <b>MARY PRENTISS</b>	14. NAME OF HUSBAND OR WIFE <b>JEWELL M. COVER</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>	16. SOCIAL SECURITY NO. <b>487-16-5224</b>	17. INFORMANT <b>MRS. JEWELL P. COVER</b> Address <b>7103 WABASH AVENUE KANSAS CITY, MISSOURI</b>
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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>EXTENSIVE cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	<b>331X</b>
	DUE TO (c) _____	

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  NO

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>11-27-57</b> to <b>11-20-57</b> and last saw him alive on <b>11-19-57</b> Death occurred at <b>2:20 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>A. R. Lyddon, Jr.</b> (Degree or title) <b>A. M. D.</b>	22b. ADDRESS <b>1027 E 75th St. MO</b>	22c. DATE SIGNED <b>11-20-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>NOV. 22 - 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>11-22-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

H. R. Lyddon, Jr. 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 *Basil Honey* .....

Licensed Embalmer No. *4724* .....  
P. O. Address *N.E. 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.