

FILED FEB 13 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1197

STATE FILE NUMBER

258

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hosp.		Length of stay in (b) 80 yrs	d. STREET ADDRESS (If outside, give location) 4026 Troost		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSEPHINE M. COCKRUM			4. DATE OF DEATH Month Jan Day 16 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1872	9. AGE (In years last birthday) 85	FUNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Jackson Co. Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME George W. McCraw		13b. MOTHER'S MAIDEN NAME Abigal Collins		14. NAME OF HUSBAND OR WIFE John O. Cockrum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-12-9162		17. INFORMANT Address -D Nora A. Connelly, 4026 Troost	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pleural Effusion Rt. -					14 days
DUE TO (c) Generalized Arteriosclerotic Heart Disease					6 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 42 yr					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.) none		
20c. TIME OF INJURY Hour 10:30 Month 10 Day 5 Year 1954 a.m. p.m.			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 10-5-1954 to 1-16-58 and last saw her ^{her} him alive on 1-16-58 Death occurred at St. Marys Hosp. 10:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) James W. Downey M.D.			22b. ADDRESS 425 E 63rd K.C. Mo.		22c. DATE SIGNED 1-17-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-18-58	23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home		ADDRESS Linwood-Woodland	25. DATE RECD. BY LOCAL REG. 1-17-58		26. REGISTRAR'S SIGNATURE neva minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

James W. Downey

Dr. James Brown
425 E 63
Ne 3-7975

12:30 PM - 4 PM

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 *John A. Johnson*
Licensed Embalmer No. *5025*
P. O. Address *Indep. 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.