

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **1321**

FILED FEB 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. **296**

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 Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital		Length of stay in 1b 1 day	
d. STREET ADDRESS 1414 W 27th St. Indep. Mo.		Reside on Farm No <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Cecil Frank Liles <i>First Middle Last</i>			4. DATE OF DEATH January 18 1958 <i>Month Day Year</i>		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1888	9. AGE (In years last birthday) 69 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Representative		10b. KIND OF BUSINESS/INDUSTRY Stationary Eng.		11. BIRTHPLACE (City and state or country) Beaver Arkansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Mark Liles		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) No		
16. SOCIAL SECURITY NO. 495-05-4400			17. INFORMANT Mrs Belle Liles 1414 W 27th Indep. Mo. <i>Address</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) Amblyos of Left Common Iliac artery DUE TO (c) Mitral Stenosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Capt of Brain Stem		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ 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 1-17-58 to 1-18-58 and last saw ^{her}him alive on 1-18-58
Death occurred at 8:10 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph H. Printz M.D.	22b. ADDRESS 701 E 63	22c. DATE SIGNED 1-20-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-21-1958	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Mem. Gardens	23d. LOCATION (City, town, or county) (State) Kansas City 33 Mo.
24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels Inc. K.C. Mo.		25. DATE RECD. BY LOCAL REG. 1-20-58	26. REGISTRAR'S SIGNATURE neva Minshel

(Licensed Embalmer's Statement on Reverse Side)

alth, welfare, public service
 300-56
 Director, coroner, etc. must use only standard nomenclature in their reports. No symptoms will be recorded. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 Joseph H. Printz

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Mr. Corie
J. H. P.
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Howe - Be
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *J. H. P.*
Licensed Embalmer No. *39*

P. O. Address *K.C.*

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.