

FILED APR 2 1958

THE DIVISION OF HEALTH OF MISSOURI
DEATH CERTIFICATE OF DEATH

58-009872
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1386

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 2336 E. 49th		Length of stay in lb 53 Yrs	d. STREET ADDRESS 2336 E. 49th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First PEARL Middle () Last CORCORAN			4. DATE OF DEATH Month 3 Day 14 Year 1958		
5. SEX Female	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 7 29 1887		9. AGE (In years last birthday) 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Humboldt, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME Fielding Jeeter		13b. MOTHER'S MAIDEN NAME Martha Bell		14. NAME OF HUSBAND OR WIFE William F	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) <input checked="" type="checkbox"/> (If yes, give year or dates of service) X X X		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. William F. Corcoran -2336 E. 49th.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Phlebotrombosis DUE TO (c) Congestive Heart Failure					INTERVAL BETWEEN ONSET AND DEATH 10 min 1 week 1 month
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.) 0			
20c. TIME OF INJURY Hour Month, Day, Year 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
21. I attended the deceased from Dec 1947 to 3/14/58 and last saw her alive on 3/14/58 Death occurred at 3/14/58 8 p. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Elias E. Zirul D.O.			22b. ADDRESS 4640 Troost		22c. DATE SIGNED 3/17/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-18-1958	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) Kansas City	(State) Missouri
24. FUNERAL DIRECTOR ADDRESS FLORAL HILLS MEM. CHAPELS, INC K.C.MO			25. DATE RECD. BY LOCAL REG. 3-17-58	26. REGISTRAR'S SIGNATURE Neva Marshall	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Elias E. Zirul

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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 embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. *3938*

P. O. Address *KC 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.