

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039887

STATE FILE NUMBER

5606

FILED DEC 11 1958

Registration District No. 149 Primary Registration District No. 1.02

Registrar's No.

300  
1-57-1

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) <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>6700 Cleveland</b>		Length of stay in lb <b>4 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>6700 Cleveland</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Lattie</b> Last <b>Cottrell</b>			4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-30-1898</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Night watchman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>K.C. Park Dept.</b>	11. BIRTHPLACE (City and state or country) <b>Dillard, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thomas Jefferson Cottrell</b>	13b. MOTHER'S MAIDEN NAME <b>Maggie Mae Hogan</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <b>NO</b> or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Julia Wikle; 7742 Antioch Rd. Park, Kan.</b>	Address <b>Overland</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>Gunshot wound of head</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (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 <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.) <b>apparently shot himself</b>
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20c. TIME OF INJURY <b>10:09 a.m. 11-26-58</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson</b>	STATE <b>MO</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Dr. C. Kealhofer, M.D. County Coroner</b>	(Degree or title) <b>3</b>	22b. ADDRESS <b>662 Prospect St. Mo</b>	22c. DATE SIGNED <b>11-26-58</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-27-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Dillard, Missouri</b>
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24. FUNERAL DIRECTOR <b>Weilert Funeral Homes; K.C., Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-27-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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All diseases in Part I must be causally related.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 Geo. C. Kealhofer

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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 *B. E. Weiler* .....

Licensed Embalmer No. *4075*  
P. O. Address *K. C. 8, 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.