

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000603

STATE FILE NUMBER

FILED FEB 9 1958 Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 17

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Excelsior Springs</u> 6002 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Hosp.</u>		Length of stay in lb <u>14 years</u>	d. STREET ADDRESS (If outside, give location) <u>310 East Excelsior St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE ETTA KARR</u>			4. DATE OF DEATH Month Day Year <u>Jan. 31, 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1892</u>
9a. AGE (in years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xxxx</u>	11. BIRTHPLACE (City and state or country) <u>Kearney, MO.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Isley</u>	
13b. MOTHER'S MAIDEN NAME <u>Ellen Frances Rowe</u>		14. NAME OF HUSBAND OR WIFE <u>Ora R. Karr (deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>xxxxx</u>		16. SOCIAL SECURITY NO. <u>490-16-0090</u>	17. INFORMANT Address <u>Mrs. Oreta Whitney, Kirkwood, MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 1/2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <u>Congestive heart failure</u>			
DUE TO (c) <u>arteriosclerosis</u>			
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year 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 <u>2/29/59</u> to <u>1/31/59</u> and last saw <u>her</u> alive on <u>1/31/59</u> Death occurred at <u>1:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.D. M. D.</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>1/31/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 3, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, MO.</u>
24. FUNERAL DIRECTOR <u>Vergil Hope</u>	ADDRESS <u>Ex. Spgs. MO.</u>	25. DATE RECD. BY LOCAL REG. <u>2-3-1959</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., must note only significant abnormalities if item 18. No symptoms or signs related. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

FEB 11 1959



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 *Chas. Virgil Hope*

Licensed Embalmer No. *3950*

P. O. Address *Excelsior Sp*

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.