

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001345

STATE FILE NUMBER

182

FILED FEB 5 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

health, Welfare Public Service  
300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
W. W. Buckingham

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>NEWTON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>FAIRVIEW</b> <b>1130</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSPITAL</b>			Length of stay in lb <b>2 WEEKS</b>			d. STREET ADDRESS (If outside, give location) <b>R.R. #1</b>		
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>A.</b> Last <b>HOOPS</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>12.</b> Year <b>1959</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT-15-1890</b> <b>68</b>		9. AGE (In years last birthday) Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) <b>CASSVILLE MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEMUEL PANNELL</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH GRIME'S</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. -		17. INFORMANT Address <b>R.R.#1</b> <b>JOHN W. HOOPS FAIRVIEW MISSOURI</b>			
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>Generalized Pulmonary Artery Thrombosis</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) _____							4-5H	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <b>Neoplastic Pleuritis Source not identified as yet</b>							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. Month, Day, Year _____								
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 <b>12-29-58</b> to <b>1-12-59</b> and last saw her alive on <b>1-12-59</b> . Death occurred at <b>4:15 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>W.W. Buckingham</b> (Degree or title)				22b. ADDRESS <b>1116 Pratt Bldg</b>		22c. DATE SIGNED <b>1/12/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>JAN. 12. 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DICE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FAIRVIEW MISSOURI</b>			
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>1-12-59</b>		26. REGISTRAR'S SIGNATURE <b>newa Marshall</b>			

7865-1002

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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.....  
*Harold E. Eckert*

Licensed Embalmer No. *70*

P. O. Address *C. C. P.*

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.