

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001483

STATE FILE NUMBER

346

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

1. PLACE OF DEATH
a. COUNTY *Jackson*
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *Kansas City* Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION *414 Olive* Length of stay in 1b *18 yrs*
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE *Mo* b. COUNTY *Jackson*
c. CITY OR TOWN *Kansas City* Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) *414 Olive* Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last *Lois Maxine Cozek*
4. DATE OF DEATH Month Day Year *1-16-59*

5. SEX *Female* 6. COLOR OR RACE *White* 7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH *5-1-1924* 9. AGE (In years last birthday) *34* IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *waitress* 10b. KIND OF BUSINESS OR INDUSTRY *Jewel Box Town Union Iowa* 11. BIRTHPLACE (City and state or country) *Iowa* 12. CITIZEN OF WHAT COUNTRY? *U.S.*

13a. FATHER'S NAME *Claude Pader* 13b. MOTHER'S MAIDEN NAME *Effie M. Morris* 14. NAME OF HUSBAND OR WIFE *Ed Cozek*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *No* 16. SOCIAL SECURITY NO. *982x* 17. INFORMANT *Charlotte Campo* Address *2819 E 6th*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Shock + Remarriage*
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO *numerous stab wounds*
DUE TO *arms chest lower back + abd*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) *982x*
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18) *Assaulted by husband*
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. *1-16-59*

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) *Residence* 20f. CITY, TOWN, OR LOCATION *Kansas City* COUNTY *Jackson* STATE *Mo*
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *Hugh H. Owens Coroner* 22b. ADDRESS *1034 Plato Pl* 22c. DATE SIGNED *1-16-59*
23a. BURIAL, CREMATION, OR REMOVAL (Specify) *Burial* 23b. DATE *1-20-59* 23c. NAME OF CEMETERY OR CREMATORY *Forest Hill Cem* 23d. LOCATION (City, town, or county) (State) *KC Mo*
24. FUNERAL DIRECTOR *Walter Wagoner* ADDRESS *K.C. Mo.* 25. DATE RECD. BY LOCAL REG. *1-19-59* 26. REGISTRAR'S SIGNATURE *Deva Marshall*

All diseases in Part I must be causally related.

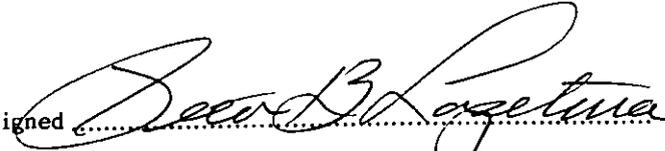
Hugh H. Owens USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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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 

Licensed Embalmer No. 4273
P. O. Address K E M O

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.