

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001527

STATE FILE NUMBER

200

JAN 28 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar No. 200

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 HICKMAN MILLS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSP Length of stay in 1b 3 WEEKS		d. STREET ADDRESS (If outside, give location) 7101 EAST 111 TERR. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last ELIZABETH SLYKER			4. DATE OF DEATH JAN. 9, 1959 Month Day Year
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 NOV. 25, 1901
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEAD CASHIER & TREAS.		9b. KIND OF BUSINESS OR INDUSTRY CREDIT UNION	9. AGE (In years less birthday) 55 57 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HEAD CASHIER & TREAS.		10b. KIND OF BUSINESS OR INDUSTRY CREDIT UNION	11. BIRTHPLACE (City and state or country) JOHNSON COUNTY, KANSAS
13a. FATHER'S NAME JAMES McCORD		13b. MOTHER'S MAIDEN NAME WILDA TOWLES	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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. 486-07-6466	14. NAME OF HUSBAND ERNEST C. SLYKER
17. INFORMANT ERNEST SLYKER. 7101 E. 111 th TERRACE Address: HICKMAN MILLS, MISSOURI		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca lungs and abdomen DUE TO (b) Ca uterus DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 1/2 yrs
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"/> 2
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 Month, Day, Year a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from May 8, 1958 to Jan 9, 1959 and last saw her alive on Jan 9, 1959 Death occurred at St. Mary's Hosp 9:00P. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Orval T. Needles M.D.		22b. ADDRESS 7400 WORNALL RD., MO.	
22c. DATE SIGNED JAN 10, 1959		22d. ADDRESS 7400 WORNALL RD., MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN. 12. 1958	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS - KANSAS CITY		25. DATE RECD. BY LOCAL REG. 1-12-59	26. REGISTRAR'S SIGNATURE never Marshall

All diseases in Part I must be causally related.

Orval T. Needles, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Vern Lawler*

Licensed Embalmer No. *4915*

P. O. Address *K.C. 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.