

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005450

STATE FILE NUMBER

695

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 8

300  
1-57

4

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital or institution) <u>3516 Summit</u> Length of stay in 1b <u>6 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>3516 Summit</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOLA</u> Middle <u>S.</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1858</u>
9. AGE (In years last birthday) <u>100</u>		F UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Drakeville, Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Jackson Noble</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Chance Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, pp. or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Dora Dohn - 3516 Summit.</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>Acute Blood Loss - HI Fract</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Metastatic Carcinoma - HI Fract</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>6-8 Months</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>97</u>			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 <u>7:00</u> Month, Day, Year <u>A</u> 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>1956</u> to <u>2-6-59</u> and last saw <u>her</u> alive on <u>1-23-59</u> Death occurred at <u>7:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Emory R. Calovich MD</u>		22b. ADDRESS <u>4620 J. C. Nichols Pkwy -K.C.</u>	22c. DATE SIGNED <u>2-6-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) (State) <u>Boone, Iowa</u>
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar 1800 Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>2-6-59</u>	26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Emory R. Calovich

All diseases in Part I must be causally related.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

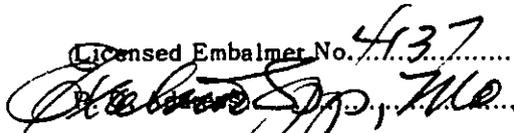
M. Calomiris  
46201  
2-6

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. 437  
  
Me.

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.