

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005495

STATE FILE NUMBER

698

Registration District No. 149

Primary Registration District No. 1001

Registration No. 698

300

1-57

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 Kansas City		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 lb 30 yrs		d. STREET ADDRESS (If outside, give location) 5911 St. John		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUELLA Middle M. Last COX			4. DATE OF DEATH Month 2 Day 4 Year 59				
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1907	9. AGE (In years) 51	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) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (City and state or country) Greene County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Fancy B. Hester			13b. MOTHER'S MAIDEN NAME Bertha Campbell			14. NAME OF HUSBAND OR WIFE Robert C. Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Robert C. Cox, 5911 St. John, K.C. Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF SUPERIOR MESENTERIC ARTERY						INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ANGIOSPASM FROM EMBOLUS						6 DAYS	
DUE TO (c) RHEUMATIC MITRAL VALVULAR DISEASE (VEGETATIVE)						5 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) UREMIC ACIDOSIS						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.							
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 7-21-54 to 2-4-59 and last saw her alive on 2-4-59 Death occurred at 11:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) James W. Fowler, M.D.				22b. ADDRESS 1103 GRAND AVE. KANSAS CITY, MO.		22c. DATE SIGNED 2-6-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-7-59	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Kansas		
24. FUNERAL DIRECTOR ADDRESS Nagora Funeral Home, K.C. Mo			25. DATE RECD. BY LOCAL REG. 2-6-59		26. REGISTRAR'S SIGNATURE Edward Marshall		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

James W. Fowler

All diseases, injuries, etc., must be causally related.

2130

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 *Thomas A. Koeller*

Licensed Embalmer No. *4995*
P. O. Address *F.C., MD.*

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.