

Health,  
Welfare  
Public  
Service

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005594

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. L009 Registrar's No. 855

300  
1-57

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| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>TOWN <u>KANSAS CITY</u>                   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>KANSAS CITY</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>ST. Joseph Hosp.</u> |  | Length of stay in 1b<br><u>27 years</u>  | d. STREET ADDRESS (If outside, give location)<br><u>5836 E 12 ST.</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <u>CARRIE</u> Middle <u>H</u> Last <u>HARPER</u> |  |  | 4. DATE OF DEATH<br>Month <u>Feb</u> Day <u>13</u> Year <u>1959</u> |  |  |  |
|---|--|--|---|--|--|--|

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|-------------------------|---------------------------------|---|---|--|---|--|
| 5. SEX<br><u>Female</u> | 6. COLOR OR RACE<br><u>CAUC</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>MARCH 28, 1902</u> | 9. AGE (In years last birthday)<br><u>56</u> | 10. F UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | 11. IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>ELECTRICAL ASSEMBLY</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Elect. Equipment</u> | 11. BIRTHPLACE (City and state or country)<br><u>ST. CHARLES, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
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| 13a. FATHER'S NAME<br><u>GILBERT SHellenhamER</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Nancy Zeigler</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Stanley Harper (deceased)</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> | 16. SOCIAL SECURITY NO.<br><u>495-24-8264</u> | 17. INFORMANT<br><u>Stanley Harper JR.</u><br>Address <u>6025 E 15 TER.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatous</u> |  | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Carcinoma of uterus</u>                   |  |   |
| DUE TO (c) <u>  </u>  |  |   |
| 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?<br>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.)<br><u>  </u> |
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|   |   |   |   |                     |                    |
|---|---|---|---|---------------------|--------------------|
| 20c. TIME OF INJURY<br>Hour <u>  </u> Month, Day, Year<br>a.m. <u>  </u> p.m. <u>  </u> | 20d. INJURY OCCURRED WHILE AT <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.)<br><u>  </u> | 20f. CITY, TOWN, OR LOCATION<br><u>  </u> | COUNTY<br><u>  </u> | STATE<br><u>  </u> |
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| 21. I attended the deceased from <u>11-1952</u> to <u>2-13-59</u> and last saw <sup>her</sup> / <sub>him</sub> alive on <u>2-13-59</u><br>Death occurred at <u>  </u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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|   |                                  |                                    |
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| 22a. SIGNATURE<br><u>R. R Coffey MD</u> (Degree or title) | 22b. ADDRESS<br><u>403 Grand</u> | 22c. DATE SIGNED<br><u>2-14-59</u> |
|---|----------------------------------|------------------------------------|

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 23b. DATE<br><u>Feb. 16, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Crown Lawn Cemetery</u> | 23d. LOCATION (City, town, or country) (State)<br><u>KANSAS CITY Missouri</u> |
|--|-----------------------------------|--|---|

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| 24. FUNERAL DIRECTOR<br><u>Muehlebach</u> | ADDRESS<br><u>6800 TROOST</u> | 25. DATE RECD. BY LOCAL REG.<br><u>2-14-59</u> | 26. REGISTRAR'S SIGNATURE<br><u>Neva Marshall</u> |
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(Licensed Embalmer's Statement on Reverse Side)

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

All diseases in Part I must be causally related.

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 *J. T. Crowell* .....

Licensed Embalmer No. *4904*

P. O. Address *J. T. Crowell* .....

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.