

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009676
STATE FILE NUMBER
1143

REG. MAR 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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) Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1516 E 8th		d. STREET ADDRESS (If outside, give location) 1516 E 8th	
Length of stay in lb 32 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MIDDLE Last ELLA F. STEELE			4. DATE OF DEATH Month Day Year 2 26 59			
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5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1885	9. AGE (In years (last birthday)) 79	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY Domestic,	11. BIRTHPLACE (City and state or country) Baraboo, Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Bishop Giles Wilcox	13b. MOTHER'S MAIDEN NAME Sylvia Lena Andrews	14. NAME OF HUSBAND OR WIFE Jack Steele
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Lois Kunellis, 4945 Agnes, K.C., Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at 10:15 A. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Brush of Owens Cemetery	(Degree or title)	22b. ADDRESS 1034 Realto Bldg	22c. DATE SIGNED 2-27-59
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23a. BURIAL, CREMATION, (REMOVAL, etc.) Cremation	23b. DATE Mch. 2, 1959	23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomer's Sons	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C., Missouri	25. DATE RECD. BY LOCAL REG. 3-2-59	26. REGISTRAR'S SIGNATURE Irene Marshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Hugh H. Owens

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 *Forrest D. Coldsnow*

Licensed Embalmer No. *4714*
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.