

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017657

STATE FILE NUMBER

2067

FILED MAY 21 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) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 510 E 8th		Length of stay in lb 2 hrs	d. STREET ADDRESS 700 S 1904 S Maywood
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last DORA MAY COCKLIN			4. DATE OF DEATH Month Day Year 4 22 59		
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 25 1917	9. AGE (In years last birthday) 41	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) File Clerk	10b. KIND OF BUSINESS OR INDUSTRY mail order	11. BIRTHPLACE (City and state of country) Little Blue, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm R Fountain	13b. MOTHER'S MAIDEN NAME Ida Lee Cadwell	14. NAME OF HUSBAND OR WIFE James Cocklin
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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. unknown	17. INFORMANT Mrs Nellie Lee Clarence Maywood Address 1904 S. 490X
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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) Tubercular meningitis		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)		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.) 490X
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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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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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/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jesse A Owens Coroner	22b. ADDRESS 1034 Walnut Blvd	22c. DATE SIGNED 4-24-59
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23a. DATE OF BURIAL CREMATION, FUNERAL (Specify) 4-27-59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City, town, or county) (State) Independence Mo
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24. FUNERAL DIRECTOR George Ford Funeral Home, Lees Summit	25. DATE RECD. BY LOCAL REG. 4-25-59	26. REGISTRAR'S SIGNATURE Neva Marshall
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(Licensed Under the State's Statement on Reverse Side)

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

High H. Owens

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, ~~of~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Forrest D. Goldanow* .....

Licensed Embalmer No. *4714* .....

P. O. Address *KP 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.