

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017734

STATE FILE NUMBER
2315

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
-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 type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Greenwood		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION S. Lukes Hosp.		Length of stay in 1b 6 Hr.	d. STREET ADDRESS (If outside, give location) 7000 0 6 Miles East of Greenwood		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Irma Marian Grogger			4. DATE OF DEATH Month Day Year May 7, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1925	9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months Days 34
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Carl Linder		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Orvel L. Grogger	
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 Address Orvel L. Grogger, Greenwood, 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) Pneumococcus Meningitis				INTERVAL BETWEEN ONSET AND DEATH 1 day	
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) 3401				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 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
21. I attended the deceased from 5-7-59 to 5-7-59 and last saw her alive on 5-7-59 Death occurred at home 10 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) L. B. Knight M.D.			22b. ADDRESS Lee's Summit Mo		22c. DATE SIGNED 5-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 11, 1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills, Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR ADDRESS Langsford Funeral Home Lee's Summit, Missouri			25. DATE RECD. BY LOCAL REG. 5-9-59	26. REGISTRAR'S SIGNATURE never Marshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

L. B. Knight

(Licensed Embalmer's Statement on Reverse Side)

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 *W B Langford*

Licensed Embalmer No. *3833*

P. O. Address *Wis. Bureau*

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.