

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021528  
STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. \_\_\_\_\_

149

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. \_\_\_\_\_

2652

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>CASS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY, MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Archie</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		Length of stay in lb <b>18 days</b>	d. STREET ADDRESS <b>019 8</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jeptha</b> Middle <b>C</b> Last <b>McKee</b>			4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>59</b>		
5. SEX <b>m</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-92</b>		9. AGE (In years last birthday) <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rock Quarries</b>		11. BIRTHPLACE (City and state or country) <b>Hays Center, Neb., U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph McKee</b>		13b. MOTHER'S MAIDEN NAME <b>MARY K. Hobbingsworth</b>		14. NAME OF HUSBAND OR WIFE <b>NORA ROBINSON MCKEE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-34-8370</b>		17. INFORMANT Address <b>NORA MCKEE Archie, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, primary undetermined</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>
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) <b>1942</b>					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 <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 <b>Aug 1958</b> to <b>5-27-59</b> and last saw him alive on <b>5-27-59</b> Death occurred at <b>3 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Harold W. Voth, M.D.</b>		22b. ADDRESS <b>201 Plaza Med. Bldg Kansas City, MO</b>		22c. DATE SIGNED <b>5-27-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAY 27, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN, K.C. MO.</b>	
				23d. LOCATION (City, town, or country) (State) <b>WARRENSPORTE, MO.</b>	
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY</b>			25. DATE RECD. BY LOCAL REG. <b>5-28-59</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Harold W. Voth

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 *Clayton Barnes* .....  
Licensed Embalmer No. 4793 .....  
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.