

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025335

FILED VS AUG 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3674 STATE FILE NUMBER

|   |   |   |  |  |  |   |   |
|---|---|---|--|--|--|---|---|
| 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>OR TOWN <u>Kansas City</u>   |   | Length of stay in 1b<br><u>2 MONTHS.</u>  |  | c. CITY OR TOWN <u>Kansas City</u>   |  | 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. Josephs Hosp.</u>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | d. STREET ADDRESS (If outside, give location)<br><u>5006 Glenside Dr.</u>  |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lela</u> Middle <u>K</u> Last <u>O'Connor</u>   |   |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>27</u> Year <u>1959</u>   |  |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</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>5-13-98</u>   | 9. AGE (last birthday)<br><u>61</u>                                      |   | IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>11</u> Hours <u>11</u> Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SCHOOL TEACHER</u>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><u>SALT LAKE CITY Utah</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |   |
| 13a. FATHER'S NAME<br><u>UNKNOWN</u>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>OSCAR O'CONNOR</u>                     |   |   |
| 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 20 3329</u>  | 17. INFORMANT Address<br><u>ARTHUR M. GRANT 5006 GLENSIDE DR.</u>  |  |   |   |
| 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>Carcinoma metastatic to lungs + femur.</u><br>DUE TO (b) <u>Carcinoma breast, left</u><br>DUE TO (c) <u>11 yrs</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input 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<br>Hour <u>4:40 P.</u> Month, Day, Year <u>July 27, 1959</u>  |   |   |  |  |  |   |   |
| 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 <u>May 16-59</u> to <u>July 27, 59</u> and last saw her alive on <u>July 27, 1959</u> .<br>Death occurred at <u>4:40 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |  |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Sam. D. Hoepfer, M.D.</u>  |   |   |  | 22b. ADDRESS<br><u>6232 Troost K.C.Mo</u>  |  | 22c. DATE SIGNED<br><u>July 28-59</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |   | 23b. DATE<br><u>JULY 30, 1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MT. MORIAH CEM.</u>                                 |  | 23d. LOCATION (City, town, or county) (State)<br><u>KANSAS CITY, MO.</u> |   |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>D.W. Newcomers Sons Kansas City, Mo.</u>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>7-29-59</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Heva Marshall</u>                        |   |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Marvin D. Preston

Licensed Embalmer No. 5040

P. O. Address Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con-  
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.