

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032591

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 4729 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>K.C. Kansas City</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4805 Indep. ave.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4805 Indep. Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Isabelle</u> Last <u>Snook</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/26</u>	9. AGE (last birthday) <u>33</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk. Drug Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Cecil B. Snook</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Berkshire</u>		14. NAME OF HUSBAND OR WIFE <u>***</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>495-20-4623</u>	17. INFORMANT <u>Elizabeth Leeds</u> Address <u>Rockville, Missouri</u>
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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) <u>Cachexia, uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Metastatic Carcinoma of Cervix</u>	<u>27 mos.</u>
	DUE TO (c)	

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>-</u>
20c. TIME OF INJURY Hour <u>-</u> Month, Day, Year <u>-</u> 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.) <u>-</u>	20f. CITY, TOWN, OR LOCATION <u>-</u>	COUNTY <u>-</u>	STATE <u>-</u>
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21. I attended the deceased from 12/8/53 to 9/27/59 and last saw her alive on 8/18/59  
Death occurred at 9/27/59 6:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William A. Leo, M.D.</u>	22b. ADDRESS <u>1612 Professional Bldg.</u>	22c. DATE SIGNED <u>9/28/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>	23d. LOCATION (City, town, county) <u>Kansas City, Missouri</u>
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24. FUNERAL DIRECTOR <u>C. H. Blackman &amp; Son Inc. K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-29-59</u>	26. REGISTRAR'S SIGNATURE <u>Neve Minshel</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF WILLIAM A. LEO

OCT 14 1959

**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 W.C. Rennie

Licensed Embalmer No. 4879

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.