

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006210

FILED VS FEB 23 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. E 717 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>64yrs</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1310 EAST ARMOUR</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3300 CHESTNUT</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Minnie</b> Last <b>Cope</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>6</b> Year <b>1960</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3 29 69</b>	9. AGE (last birthday) <b>90 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>ADRIAN MISSOURI</b>		11. BIRTHPLACE (City and state or country) <b>USA.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA.</b>	
13a. FATHER'S NAME <b>WILLIAM NICHOLS</b>			13b. MOTHER'S MAIDEN NAME <b>ADELINE GUTSCHALL</b>			14. NAME OF HUSBAND OR WIFE <b>GEORGE COPE</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>NO</b>		17. INFORMANT Address <b>R.O. COPE 6425 WALNUT</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>Chronic myocarditis with cardiac decompensation</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 years</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>Senility</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. p.m. Month, Day, Year									
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 <b>January 19, 1959</b> to <b>Feb. 6, 1960</b> and last saw her <del>xxx</del> alive on <b>Feb. 4, 1960</b>									
Death occurred at <b>12:55 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Ralph Perry MD</i>				22b. ADDRESS <b>4800 E. 24th street</b>			22c. DATE SIGNED <b>2-6-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>FEB 8, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS K.C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>2-8-60</b>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Ralph Perry

NOV 8 1961

**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 Bern Lawler

Licensed Embalmer No. 4915

P. O. Address K. G. M.

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.