

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-029431

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3913

AMENDED

FILED AUG 25 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 12 Days	c. CITY OR TOWN Mission Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5438 Lamar Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HELEN Middle C. Last LEY			4. DATE OF DEATH Month August Day 3 Year 1961		
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 8/9/1908	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Patrick J. Corvill		13b. MOTHER'S MAIDEN NAME Sarah Farrish		14. NAME OF HUSBAND OR WIFE J. Gus Ley Sr	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address J. Gus Ley, 5438 LAMAR, MISSION KS
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Liver failure, portal vein thrombosis 48 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Liver metastasis — 3 mo.	
DUE TO (b)	Carcinoma of left breast 2 yrs	
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

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.)
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20c. TIME OF INJURY Hour 2:30 Month Aug Day 7 Year 1961 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 Mission	COUNTY Johnson	STATE Kansas
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21. I attended the deceased from **May 7, 1961** to **Aug 3, 1961** and last saw her **alive** on **August 3, 1961**
Death occurred at **2:30 PM** m of the date stated above, and to the best of my knowledge, from the causes stated.

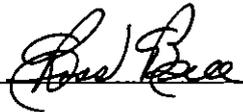
22a. SIGNATURE (Degree or title) S. Cooper MD	22b. ADDRESS Professional Bldg., K.C. Mo.	22c. DATE SIGNED 8/4/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 7, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
24. FUNERAL DIRECTOR Jos. A. Butler's Sons, K. C. Kansas	25. DATE RECD. BY LOCAL REG. 8-7-61	REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 _____


Licensed Embalmer No. 3426 Missouri

P. O. Address Kansas City 2, Kan

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.