

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-006738

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1023

FILED MAR 7 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 74 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Colonial Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2704 Campbell Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALMIRA Middle CARTMELL Last TOBIAS	4. DATE OF DEATH Month February Day 19 Year 1962
--	--

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 1-7-1885	9. AGE (last birthday) 77	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) Operator of Nurses Registry	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Litchfield, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	-----------------------------------	---	--

13a. FATHER'S NAME T. W. Graves	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Guy O. Tobias
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Lyman Ketchum 1852 North 30th Kansas City, Mo. Address
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Ventricular Fibrillation	INTERVAL BETWEEN ONSET AND DEATH Immediate
---	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **Carcinomatosis, Uterus**

DUE TO (c) **Generalized Metastasis**

with **1 year**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Arteriosclerosis, Generalized.

PART III. If deceased was female was there a pregnancy in last 90 days.

Yes No Unknown

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 (If INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
---	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Nov 61 to 18 Feb '62 and last saw her alive on 18 Feb. 1962.
Death occurred at 19 Feb. '62 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (If Degree or Title) Hallace H. Graham M.D.	22b. ADDRESS 518 Argyle Bldg.	22c. DATE SIGNED 19 Feb. '62
--	---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-21-62	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR Freeman Mortuary Kansas City, Missouri	ADDRESS	25. DATE RECD. BY LOCAL REG. 2-20-62	26. REGISTRAR'S SIGNATURE Ruth Long
---	---------	--	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 SHOULD READ
 AFFIDAVIT OF
 MEDICAL CERTIFICATION
 Hallace H. Graham

In Wallace Graham
Argyle Bldg
Aca 1-0111

2-430

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 A. Barnes

Licensed Embalmer No.

4793

P. O. Address

K.R. 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.