

No. 2
4-13-40
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37799**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4397**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Jackson**
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **Lakeside Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **37 years**
In this community **37 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dr. Lillian V. McKenzie**
3. (b) If veteran, name war **XX**
3. (c) Social Security No. **No**

4. Sex **Fe** 5. Color or race **Wh**
6. (a) Single, widowed, married, divorced **Sgl**
6. (b) Name of husband or wife **XX**
6. (c) Age of husband or wife if alive **XX** years
7. Birth date of deceased: **August 31 1881**
(Month) (Day) (Year)

8. AGE: Years **59** Months **2** Days **15** If less than one day hr. min.

9. Birthplace **Oakland Calif.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Doctor of Osteopathy**

11. Industry or business
12. Name **Peter M. McKenzie**
13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Millie Cook**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Thomas H. McKenzie**
(b) Address **Panhandle, Texas**

17. (a) **Cremation** (b) Date thereof **11-18-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood Cemetery**

18. (a) Signature of funeral director **J.W. Wagner**
(b) Address **Kansas City, Mo.**

19. (a) **11-18-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **4216 Chestnut**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **16th**
year **1940** hour **2:00** minute **A.** M.
21. I hereby certify that I attended the deceased from **Oct. 14, 1940**
to **Nov. 16, 1940**
that I last saw h. **ER** alive on **Nov. 16, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Colon** **few mos.**
(indefinite onset)

Due to _____
Due to **46**
Other conditions **Non-specific aorto-coronary disease**
(Include pregnancy within 3 months of death)
Major findings: **Carcinoma of colon with intestinal obstruction**
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury **3**
23. Signature **E. J. Schindler** M. D. or other **D. O.**
Address **421 Shukert Plaza** Date signed **11/18-40**

FEB 10 1945

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed W. R. Haunschild
Licensed Embalmer No. 4159
P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.