

S. No. 2
M-5-43
v. 5-17-39
I X36671

23069

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 13 1945

Registration District No.

Primary Registration District No. 1002

Registrar's No. 3279

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community 4 years

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. 2812 Prospect
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME BARBARA LORENCE

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 29, 1929
(Month) (Day) (Year)

8. AGE: Years 15 Months 11 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Esbon Kan. 1
(City, town, or county) (State or foreign country)

10. Usual occupation School Girl

11. Industry or business School

MOTHER FATHER

12. Name Anton V. Lorence

13. Birthplace Esbon Kan. 1
(City, town, or county) (State or foreign country)

14. Maiden name Bernice Crosier

15. Birthplace Wymore Neb. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Anton V. Lorence

(b) Address 2812 Prospect, K.C. Mo.

17. (a) Removal (b) Date thereof 8/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Esbon, Kan.

18. (a) Signature of funeral director Melody-McGilley-Eylan

(b) Address 1800 Linwood Blvd. K.C. Mo.

19. (a) 8-4-45 (b) Geraldine Helme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 3 rd
year 1945 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from _____, 19____ to 8-3, 1945
that I last saw her alive on 8-3, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Peripheral Circulatory Failure

Due to Lymphoid hyperplasia with persistent enlarged thymus

Due to congenital Hypoplastic Heart & Aorta

Other conditions: Shock
(Include pregnancy within 3 months of death)

Major findings: none

Of operations none

Of autopsy 1572

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 8-3-45

(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? _____

(Specify type of place)

While at work? _____ (e) Means of injury fall

23. Signature Ralph Mueller, M.D.
Address 600 Oak Bay Date signed 8-3-45

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 Russell A. Lane

Licensed Embalmer No. 4255

P. O. Address. K. B. 220

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.