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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1549**

Registration District No. **149** Primary Registration District No. **1002**

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:
4223 Windsor Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community **45 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **4223 Windsor Ave.** **8**
(If rural, give location) **0**

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **MRS. MARY OLIVE LOCKRIDGE**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Fe** 5. Color or race **W**

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

6. (b) Name of husband or wife **Ralph D.**

6. (c) Age of husband or wife if alive **87** years

7. Birth date of deceased **Oct 4 1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **2**
year **1947** hour **8** minute **30** A. M.

21. I hereby certify that I attended the deceased from **April 1** 19**47**, to **April 2** 19**47**,
that I last saw h. **er** alive on _____ 19**47**,
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
77	5	28	hr. _____ min. _____

Immediate cause of death **Carcinoma of Rectum** **2 yrs** Duration

Due to _____

Due to _____

Other conditions **none**
(Include pregnancy within 3 months of death)

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Major findings:
Of operations _____

Of autopsy **no**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER { 12. Name **Charles Notson**

13. Birthplace **Philladelphia Pa.**
(City, town, or county) (State or foreign country)

14. Maiden name **Loretta Brokaw**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(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? _____

16. (a) Informant **Richard Lockridge**
72 Washington Place
(b) Address **New York, 11 New York**

17. (a) **Cremation** (b) Date thereof **April 5-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood**

18. (a) Signature of funeral director **J. W. Wagner**

(b) Address **Kansas City Mo.**

19. (a) **4-4-47** (b) **Arladine Holmes**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature **Chas S Nelson** (M. D.)
Address **3626 Independence** Date signed **4-4-47**

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

3626 1/2 Street,
Ok 2172
Doro J. Hines
Dory Nancy Hines 1931.

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 Alvin R. Haenschel
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.