

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21038**
Registrar's No. **2836**

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

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

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days) 10 years

3. (a) PRINT FULL NAME Frank M. Lancaster
 3. (b) If veteran, name war No
 3. (c) Social Security No. unknown

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife *
 6. (c) Age of husband or wife if alive * years
 7. Birth date of deceased: 11 1 1882
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 1
 If less than one day hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

MOTHER FATHER
 11. Industry or business
 12. Name Henry Jefferson Lancaster
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Martha Jane Smith
 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Harry H. Lancaster
 (b) Address 5512 East 12th. Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address Kansas City, Missouri

19. (a) 7-3-47 Geraldine Holmes
(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. 3231 Prospect
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 2
 year 1947 hour 7 minute 38 A.M.
 21. I hereby certify that I attended the deceased from June 30, 1947 to July 2, 1947;
 that I last saw him alive on July 2, 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Old cerebrovascular accident
Confluent bronchopneumonia

Due to _____
 Due to _____

Other conditions 830
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: See above
 Of operations _____
 Of autopsy _____
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 0
 23. Signature Wm W. Ward (M. D. or other) 7-3-47
 Address Med. Dir. Gen'l Hosp Date signed _____

20 July 1968

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 *Robert A. Herrmann*
Licensed Embalmer No. *3700*
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.