

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23493**  
**3209**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>	PRIMARY REG. DIST. NO. <u>1002</u>	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Kansas City</b> )		c. LENGTH OF STAY (in this place) <u>2.7 years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital No. 1</b>		d. STREET ADDRESS (If rural, give location) <b>1420 E. 30 St.</b>		
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Mary</b>	b. (Middle) _____	c. (Last) <b>Lindsay</b>
4. DATE OF DEATH		(Month) <b>7</b>	(Day) <b>23</b>	(Year) <b>1949</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 12, 1864</b>	9. AGE (in years last birthday) <b>84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Astoria Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Samuel Stevens</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Dwyson</b>	14. NAME OF HUSBAND OR WIFE <b>James Lindsay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Teresa Scanlon</b> ADDRESS <b>1420 E. 30th</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of cervix with metastases</b>		INTERVAL BETWEEN ONSET AND DEATH _____		
ANTECEDENT CAUSES		DUE TO (b) _____		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____		
22. I hereby certify that I attended the deceased from <u>May 13, 1949</u> , to <u>July 23, 1949</u> , that I last saw the deceased alive on <u>July 23, 1949</u> , and that death occurred at <u>5:40 A.M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE <b>Wm. W. Hart</b> (Degree or title)		23b. ADDRESS <b>Med. Dir. Gen'l Hosp.</b>		23c. DATE SIGNED <b>7-23-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-25-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>	24d. LOCATION (City, town, or county) (State) <b>K.C. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7-25-49</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b>	25. FEDERAL DIRECTOR'S SIGNATURE <b>D.W. Newcome's Sons</b> ADDRESS <b>K.C. Mo.</b>		

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

*Dr. Mueggen*

**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 \_\_\_\_\_

Student Embalmer

Signed

*James T. Dew*

Licensed Embalmer No. *4453*

P. O. Address *Thomas City*

**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.