

FILED SEP 2 1949

STANDARD CERTIFICATE OF DEATH

State File No. 27101

3553

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3553

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 65 years		d. STREET ADDRESS (If rural, give location) 100 E. 36th St. 212 Westport Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Colonial Nursing Home			

3. NAME OF DECEASED (Type or Print) a. (First) Mrs Mary Mamie b. (Middle) Zimmerman c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) August 12, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH June 27, 1884	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.	

13a. FATHER'S NAME Neville	13b. MOTHER'S MAIDEN NAME Malone	14. NAME OF HUSBAND OR WIFE Edward C. Zimmerman
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE AND ADDRESS William A. Zimmerman 905 W. 40th Ter
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lungs, and mediastinum		INTERVAL BETWEEN ONSET AND DEATH 5-6 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 164 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Kansas City Mo
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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?
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22. I hereby certify that I attended the deceased from **May**, 19**49**, to **Aug 11**, 19**49**, that I last saw the deceased alive on **Aug 11**, 19**49**, and that death occurred at **10:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Ott F. Reisman (Degree or title)	23b. ADDRESS 601 Schubert Bldg KC Mo	23c. DATE SIGNED Aug 13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 16, 1949	24c. NAME OF CEMETERY OR CREMATORY St. Marys	24d. LOCATION (City, town, or county) (State) K. Mo.
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DATE REC'D BY LOCAL REG. 8-16-49	REGISTRAR'S SIGNATURE Theraline Holmes	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Thomas E. Quirk 4316 Troost Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Thomas E. Lusk

Student Embalmer

Licensed Embalmer No..... 2775

P. O. Address..... A. E. M.

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.