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FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27152

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prairie Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prairie Twp.	
c. LENGTH OF STAY (in this place) 12		d. STREET ADDRESS (If rural, give location) 1/2 Mi. East Lee's Summit	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1/2 Mi East Lee's Summit			

3. NAME OF DECEASED (Type or Print) a. (First) Levi b. (Middle) Valentine c. (Last) Tudor			4. DATE OF DEATH Aug. 26 1949 (Month) (Day) (Year)		
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5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 27 1855		9. AGE (In years last birthday) 94		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Linden Ohio.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
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13a. FATHER'S NAME Miles Tudor			13b. MOTHER'S MAIDEN NAME Mary Thorp			14. NAME OF HUSBAND OR WIFE Emma S. Tudor		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Kathryne Tudor Lee's Summit, Mo.				ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cerebral Thrombosis						3 days	
DUE TO (b)		DUE TO (c)						1 year	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								331X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMEICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 **7-31**, 19**49**, to **8-26**, 19**49**, that I last saw the deceased alive on **8-26**, 19**49** and that death occurred at **3:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)			23b. DATE SIGNED 8-26-49		
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-28-1949		24c. NAME OF CEMETERY OR CREMATORY Lee's Summit, Mo.		24d. LOCATION (City, town, or county) (State) Lee's Summit, Missouri	
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DATE REC'D BY LOCAL REG. AUG. 29, 1949		REGISTRAR'S SIGNATURE Russell C. Enns		FEDERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Lee's Summit, MO.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed.....

N. B. Langford

Licensed Embalmer No. 3833.....

Signed.....

Student Embalmer

P. O. Address Lee's Summit, Missou

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.