

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1950

State File No. **1812**  
**574**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>23 Yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>5418 Saída</u> <u>3060</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary Elizabeth Lassiter</u> b. (Middle) <u>Gale</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7, 1950</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>July 20, 1915</u>		9. AGE (In years last birthday) <u>34</u> 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) <u>Housewife</u>		10b. KIND OF BUSINESS* OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Arleigh Lassiter Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Hunter</u>		14. NAME OF HUSBAND OR WIFE <u>Lawrence Gale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-03-6245</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lawrence Gale 5418 Saída</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Noddy's Disease (see below)</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>  <u>201 X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
19a. DATE OF OPERATION <u>2-6-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Intestinal obstruction, peritonitis, mesenteric lymphadenitis</u>					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) (Min.)		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>July 5, 1949</u> , to <u>Feb. 6, 1950</u> , that I last saw the deceased alive on <u>Feb. 6, 1950</u> , and that death occurred at <u>2:10 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Arthur B. Smith M. D.</u>			23b. ADDRESS <u>830 Arroyo Blvd. Kansas City Mo.</u>		23c. DATE SIGNED <u>Feb. 7, 1950</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 9, 1950</u>	24c. NAME OF CEMETERY OR CREMATOR <u>Mt. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>		
DATE REC'D BY-LOCAL REG. <u>2-7-50</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earp &amp; Sons</u>		ADDRESS <u>4139 Truman Rd.</u>	

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

*lymphadenopathy*

**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 *William K. Carpe*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *4728*

P. O. Address *K.C. 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.