

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33685**
4575

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

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) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City, Mo.	
c. LENGTH OF STAY (in this place) 20 YRS.		d. STREET ADDRESS (If rural, give location) 2901 Olive 3403	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2901 Olive			

3. NAME OF DECEASED (Type or Print) a. (First) Florence b. (Middle) _____ c. (Last) Lee			4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1957		
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5. SEX Fe 3		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH May 10, 1897		9. AGE (In years last birthday) 54		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) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brookline, Mass.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
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13a. FATHER'S NAME Freeman Moore			13b. MOTHER'S MAIDEN NAME Phillis Mc Kee			14. NAME OF HUSBAND OR WIFE Henry Lee, deceased					
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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) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Rosia Spruell, dau. K.C. Mo.							
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocarditis ANTECEDENT CAUSES Chronic Arteriosclerosis DUE TO Atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH 42 1/2	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION History from Clinic & Physician						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) 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) Thos. A. Jones				23b. ADDRESS 1612 E 12 st				23c. DATE SIGNED 10/26/57			
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 30, 57		24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery				24d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
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DATE REC'D BY LOCAL REG 10-27-57		REGISTRAR'S SIGNATURE Seraldine Holmes				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Adkins Bros. Funeral Home K.C. Mo.					
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WRITE PLAINLY—USING UNFAADING 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.....

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working under my personal supervision.

Student Embalmer No.....

Signed *C Kenneth Reynolds*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4437*

P. O. Address *7600 Elm*

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.