

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20335**
2755

FILED JUL 5 1952

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

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| 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 KANSAS CITY | | c. LENGTH OF STAY (In this place) 11 YRS | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY | | 10 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 801 FOREST | | | d. STREET ADDRESS (If rural, give location) 801 FOREST | | |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) WASHINGTON c. (Last) BABCOCK | | | 4. DATE OF DEATH (Month) (Day) (Year) JUNE 15 1952 | | |
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|--------------------------------|----------------------------------|--|---|--|---------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX 0 MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 5 APRIL 1875 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 1 HRS. Min. |
|--------------------------------|----------------------------------|--|---|--|---------------------------|-------------------------|--------------------------|-------------------------|

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|--|--|---|--|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER | | 10b. KIND OF BUSINESS OR INDUSTRY LAW | | 11. BIRTHPLACE (City and State or Foreign Country) ARCADIA, MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
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| 13a. FATHER'S NAME AUGUST J. BABCOCK | | 13b. MOTHER'S MAIDEN NAME FANNIE MAY | | 14. NAME OF HUSBAND OR WIFE EMILY A. BABCOCK | | | |
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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 E. A. BABCOCK | | | | ADDRESS 801 FOREST 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary, both lower extremities 4 mo. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4501 | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arterio-sclerosis | | | | | | | |
| | DUE TO (c) Hypertension | | | | | | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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|------------------------|--|----------------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) | |
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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? | |
|---|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from Aug. 1946, to June 15, 1952, that I last saw the deceased alive on June 14, 1952, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

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|---|--|--|---|--|------------------------------------|--|
| 23a. SIGNATURE Charles K. Lakay Jr. M.D. (Degree or title) | | | 23b. ADDRESS 2700 Tracy K.C. Mo | | 23c. DATE SIGNED 6/16/52 | |
|---|--|--|---|--|------------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE JUNE 17-52 | | 24c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS | | 24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI | |
|--|--|--------------------------------|--|---|--|---|--|

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|--|--|--|--|---|--|--|--|---------|--|
| DATE REC'D BY LOCAL REG. 6-17-52 | | REGISTRAR'S SIGNATURE Geraldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE FLORAL HILLS MEMORIAL CHAPELS K.C. MO. | | | | ADDRESS | |
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(Licensed Embalmer's Statement on Reverse Side)

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

27

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 Oriss Blanford

Licensed Embalmer No. 4015

P. O. Address Ke 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.