

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44557

State File No. 5783

FILED JAN 17 1953

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

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

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 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) About 9 Mo		d. STREET ADDRESS (If rural, give location) 2701 E. 30th. St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2701 E. 30th. St.			

3. NAME OF DECEASED (Type or Print) a. (First) WILMOTH		b. (Middle) ANDERSON		c. (Last) LOCKHART		4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1952	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 31, 1888		9. AGE (In years last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Athens, Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Joseph Phelps		13b. MOTHER'S MAIDEN NAME Jane Harwell		14. NAME OF HUSBAND OR WIFE William T. Lockhart	
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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. Elizabeth Perkins-2701 E. 30th.	
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocarditis		INTERVAL BETWEEN ONSET AND DEATH 43 hr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) obscure		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Nephritis		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kansas City, Jackson, Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from **11-18-52** to **12-24-52**, that I last saw the deceased alive on **12-24-52**, and that death occurred at **2:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Henry B. Lyons (Degree or title) MD	23b. ADDRESS 1605 E. 18th St.	23c. DATE SIGNED 12-30-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/31/52	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. 12-31-52	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. Sterling Bull 1212 Vine
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STATEMENT BY LICENSED EMBALMER

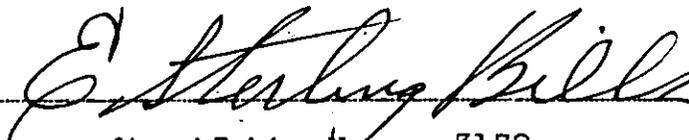
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 3178

P. O. Address 1212 Vine St., Kansas C.

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.