

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21532**
Registrar's No. **2863**

FILED JUL 9 - 1953
BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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 OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 2 YEARS	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION 7425 Virginia Avenue		e. STREET ADDRESS (If rural, give location) 7425 Virginia Avenue 3900	
3. NAME OF DECEASED (Type or Print) EVERETT J. DOLPH		4. DATE OF DEATH (Month) (Day) (Year) JUNE 6 - 1953	
5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN-19-1878
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	
11. BIRTHPLACE (City and State or Foreign Country) HASTINGS, IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOSIAH DOLPH		13b. MOTHER'S MAIDEN NAME SUSAN RIDDELL	
14. NAME OF HUSBAND OR WIFE MRS. DOROTHY DOLPH		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 MRS. DOROTHY DOLPH	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate ANTECEDENT CAUSES metastases Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) _____		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 9-1- , 19 40 , to 6-6- , 19 53 , that I last saw the deceased alive on 5-16 , 19 53 and that death occurred at 5:25A m., from the causes and on the date stated above.	
23a. SIGNATURE H. B. Lydon Jr. (Degree or title) MD		23b. ADDRESS 1027 E 75th Ave. MO	
23c. DATE SIGNED 6-6-53		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE JUNE 9, 1953		24c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY	
24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI		25. FUNERAL DIRECTOR'S SIGNATURE (Print name and address) W. M. ... Kansas City, Missouri	
DATE REC'D BY LOCAL REG. 6-8-53		REGISTRAR'S SIGNATURE Deraldine Smith	

WRITE PLAINLY—USING UNFADEING 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Robert Ray

Licensed Embalmer No. 418

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.