

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24956

State File No.

FILED AUG 13 1953

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3751

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). b. STATE Mo. c. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas city		c. CITY OR TOWN K.C. Kansas city	
d. FULL NAME OF HOSPITAL OR INSTITUTION The Childrens Mercy Hosp.		e. STREET ADDRESS (If rural, give location) 5218 N 1732 Fuller	
3. NAME OF DECEASED (Type or Print) a. (First) Velvet b. (Middle) Mary c. (Last) Go LLOYD.		4. DATE OF DEATH (Month) (Day) (Year) 7 28 53	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WID.	8. DATE OF BIRTH aug 6, 1948
9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) X	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (City and State or Foreign Country) General Hosp K.C. Mo. O	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Neville DeRay Lloyd		13b. MOTHER'S MAIDEN NAME Betty Louise Hughes.	
14. NAME OF HUSBAND OR WIFE none.		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. no		17. INFORMANT'S SIGNATURE OR NAME Betty Louise Casey K.C.	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Acute fibrinous pleuritis 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 checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 491X	
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 Pathologist , 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 H. M. Gilkey (Degree or title) MD		23b. ADDRESS 1424 Proj Bldg.	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 7-31-53		24c. NAME OF CEMETERY OR CREMATORY Floral Hill	
24d. LOCATION (City, town, or county) (State) Kansas City Mo		25. FUNERAL DIRECTOR'S SIGNATURE John P. Shul	
25. FUNERAL DIRECTOR'S ADDRESS K.C. Mo		DATE REC'D BY LOCAL REG. 7-29-53	
REGISTRAR'S SIGNATURE Sheraldine Smith		ADDRESS	

W-4521

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.....
Licensed Embalmer No.....

P. O. Address.....

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.