

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35963**
4968

FILED NOV 2 - 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 MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Buckner	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 yr		STREET ADDRESS (If rural, give location) Six Mi South	
d. FULL NAME OF HOSPITAL OR INSTITUTION Campbell Nursing Home			
3. NAME OF DECEASED (Type or Print) a. (First) Frances		b. (Middle) Hannah	
c. (Last) Lunceford		4. DATE OF DEATH (Month) (Day) (Year) Oct 16, 1953	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH Dec 3 1873
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Bucannon Co Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Brammer		13b. MOTHER'S MAIDEN NAME Mary Gore	
14. NAME OF HUSBAND OR WIFE Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME May Hodges		ADDRESS Buckner Mo	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Debrility	
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) (m.)		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 10-15-1953 to 10-16-1953 that I last saw the deceased alive on 10-15-1953 , and that death occurred at 7:40A m., from the causes and on the date stated above.			
23a. SIGNATURE Thos S Gage (Degree of title) MD		23b. ADDRESS 1803 Jackson	
23c. DATE SIGNED 10/16/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE oct 18 1953	
24c. NAME OF CEMETERY OR CREMATORY Oakland Cem		24d. LOCATION (City, town, or county) (State) Buckner Mo	
DATE REC'D BY LOCAL REG. 10-16-53		REGISTRAR'S SIGNATURE Seraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home		ADDRESS Blue Springs Mo	

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..... *R B Webb*

Licensed Embalmer No. *2352*

P. O. Address *Blaine Spr*

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.