

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16188  
1991

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>13 Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3226 Agnes Street</u>		d. STREET ADDRESS (If rural, give location) <u>3226 Agnes Street</u>	

3. NAME OF DECEASED (Type or Print) <u>Lois Florence Spicer</u>			4. DATE OF DEATH <u>May 2, 1954</u>		
a. (First)		b. (Middle)		c. (Last)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-26-1907</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Kilborne, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>

13a. FATHER'S NAME <u>Charles Hutton</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Belle Smith</u>		14. NAME OF HUSBAND OR WIFE <u>Walter C. Spicer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>513-20-3811</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Walter C. Spicer, Kansas City, Mo.</u>	
(If yes, give war or dates of service)		(If yes, give war or dates of service)		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Adenocarcinoma</u>			<u>8 months</u>
		ANTECEDENT CAUSES			
		<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) <u>Bronchiogenic Adenocarcinoma</u></p>			<u>10 months</u>
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS			<u>102X</u>
		<p>Conditions contributing to the death but not related to the disease or condition causing death.</p> <p><u>None.</u></p>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 29 April, 1954, to 2 May, 1954, that I last saw the deceased alive on 29 April, 1954, and that death occurred at 2:00 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Philip G. Kaul MD</u> (Degree or title)		23b. ADDRESS <u>711 Nichols Road</u>		23c. DATE SIGNED <u>3 May 54</u>	
---	--	--------------------------------------	--	----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>May 4, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>	
---	--	------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <u>5-3-54</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gates Funeral Home, Kansas City, Kansas</u>		ADDRESS	
--	--	--	--	---	--	---------	--

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Hall  
Plaza. Same body.  
JE 1226  
1:30 to 1:45

**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 Charles W. Bennett  
Licensed Embalmer No. 4932  
P. O. Address F. C. 10 740

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.