

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 17 1954

State File No. 16295

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 4239 Registrar's No. 81

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 township) OR TOWN Lee's Summit		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lee's Summit	
c. LENGTH OF STAY (In this place) 45 yrs		d. STREET ADDRESS (If rural, give location) 109 South Douglas	
d. FULL NAME OF HOSPITAL OR INSTITUTION 109 South Douglas		109 South Douglas	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Martha c. (Last) Sickler			4. DATE OF DEATH (Month) (Day) (Year) May 7, 1954		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 26, 1902	9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Garden City, Kansas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME W. B. George		13b. MOTHER'S MAIDEN NAME Mary Lynch		14. NAME OF HUSBAND OR WIFE	
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. 489-30-3230		17. INFORMANT'S SIGNATURE OR NAME Sara G. Barns. Lee's Summit, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventriculo-fibrillation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial Asthma DUE TO (c)		
II. 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 241X		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 1-6-1953, to 5-7-1954, that I last saw the deceased alive on 5-7-54, 19, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Cliff R. Miller M.D.</i>		23b. ADDRESS Lee's Summit 200		23c. DATE SIGNED 5-8-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 9, 1954		24c. NAME OF CEMETERY OR CREMATORY Lee's Summit	
		24d. LOCATION (City, town, or county) Lee's Summit, Mo.			

DATE RECD BY LOCAL REG. 5/19/54		REGISTRAR'S SIGNATURE <i>W.B. Langford</i> 483		25. FUNERAL DIRECTOR'S SIGNATURE <i>W.B. Langford</i> ADDRESS Lee's Summit	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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JUN 20 1957

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 *H. B. Langsford*

Licensed Embalmer No. 3833

P. O. Address *Leis Summit*

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.