

FILED OCT 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34124

State File No.

4692

BIRTH NO. 1364387600-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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 Kansas City		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2207 Charlotte		3. STREET ADDRESS (If rural, give location) 31 2207 Charlotte	

3. NAME OF DECEASED (Type or Print) a. (First) Linda b. (Middle) Denise c. (Last) Samuels		4. DATE OF DEATH (Month) (Day) (Year) Oct. 7 1954	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Nov. 28, 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min. 10 9
11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo. 0		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Alexander Samuels		13b. MOTHER'S MAIDEN NAME Nina Bingham		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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alexander Samuels 2207 Charlotte	

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, assthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bilateral Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 490x
	2. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) (Rad Hepatization)		
	3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophied Thyroid		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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 _____, 19____, to _____, 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 Deputy Coroner		23b. ADDRESS 1618 Lydia Ave		23c. DATE SIGNED 10/9/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 9, 1954	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		

DATE REC'D BY LOCAL REG. 10-8-54	REGISTRAR'S SIGNATURE Neva Minshall	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Bros. Funeral Home	ADDRESS 18th Street
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
L. M. Tillman

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 *Bruce R. Watkinson*.....

Licensed Embalmer No. *45*.....

P. O. Address *18th Penn*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.