

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34294**

FILED NOV 8 - 1954

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **5368** Registrar's No. **424**

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) Mt. Washington Kansas City		c. CITY (If not in hospital or institution, give street address or location) Mt. Washington Kansas City	
c. LENGTH OF STAY (in this place) 3 yrs		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 9117 Schope (Rural, Blue)		STREET ADDRESS (If rural, give location) 9117 Schope	

3. NAME OF DECEASED (Type or Print) a. (First) Donald b. (Middle) Gilbert c. (Last) Strain	4. DATE OF DEATH (Month) (Day) (Year) Oct. 26, 1954.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. II, 1951.	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kansas City Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Cecil Strain	13b. MOTHER'S MAIDEN NAME Linda Adamson	14. NAME OF HUSBAND OR WIFE Name
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Cecil Strain	ADDRESS 9117 Schope Mt. Washington Kansas City Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neurocytoma of Mesenteric		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) - Lymph Glands. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1981			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Neurocytoma - inoperable filling abdomen	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Kansas City Jackson MO.
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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?
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22. I hereby certify that I attended the deceased from **9-9, 1954**, to **10-26, 1954**, that I last saw the deceased alive on **9-26, 1954**, and that death occurred at **4:20a m.**, from the causes and on the date stated above.

23a. SIGNATURE D. A. Lockwood M.D.	(Degree or title) 9	23b. ADDRESS 11037 Venice Rd.	23c. DATE SIGNED 10-26-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 28, 1954.	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 10-28-54	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Forster Funeral Home Kansas City Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

7000

Dr. Cockerell
11037 Winner Rd.
Cl. 3900

10-21-14
J. M. Owens

1961 8 10 AM

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..... *Dean Owens*

Licensed Embalmer No. *428*

P. O. Address *K.C., Mo*

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.