

FILED DEC 27 1954

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41058**  
**5422**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 199 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) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (in this place) <u>8 YEARS</u>		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 <u>8445 FLORA AVENUE</u>		STREET ADDRESS (If rural, give location) <u>95 8445 FLORA AVENUE</u>	
3. NAME OF DECEASED a. (First) <u>ALLEN</u> b. (Middle) <u>BENTON</u> c. (Last) <u>LASSWELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 23, 1954</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept. 24, 1864</u>
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (City and State or Foreign Country) <u>BEDFORD, IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BENJAMIN LASSWELL</u>		13b. MOTHER'S MAIDEN NAME <u>— SNODGRASS</u>	
14. NAME OF HUSBAND OR WIFE <u>ELIZABETH LASSWELL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ELIZABETH LASWELL, 8445 FLORA, K.C. Mo.</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac Failure</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Oedema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
DUE TO (c) <u>Bronchial Pneumonia</u>		<u>24 hrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Arteriosclerosis</u>		<u>4 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>491X</u>	
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)		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 <u>July 24, 1954</u> , to <u>Nov. 23, 1954</u> , that I last saw the deceased alive on <u>Nov 23, 1954</u> , and that death occurred at <u>9:45 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Donald R. Collins</u>		23b. ADDRESS <u>210 Woodland</u>	
23c. DATE SIGNED <u>11/24/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>Nov. 24 1954</u>	
24c. NAME OF CEMETERY OR CREMATORY —		24d. LOCATION (City, town, or county) (State) <u>MEDICINE LODGE KANSAS</u>	
DATE REC'D BY LOCAL REG. <u>11-24-54</u>		REGISTRAR'S SIGNATURE <u>new Minshall</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>K.C. Mo. 1331 BRUSH CREEK Bld</u>	

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

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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 *James T. Dewar*

Licensed Embalmer No. *445*

P. O. Address *Hawaii*

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.