

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 18 1955

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar No. <u>351</u>	
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 town) <u>Kansas City</u>			c. LENGTH OF STAY (in this place) <u>25 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>				STREET ADDRESS (If rural, give location) <u>4145 Locust</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LUCY</u>		b. (Middle) <u>S.</u>		c. (Last) <u>ANDREWS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 25 55</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-29-1873</u>		9. AGE (In years) (Last birthday) <u>81</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xx</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Peoria, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>No Record</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda Smith</u>		14. NAME OF HUSBAND OR WIFE <u>James M. Andrews</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>xx</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mildred Swanson, 4145 Locust</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Auricular Fibrillation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Vascular accident and Thrombus in Right Iliac & Femoral Artery</u> DUE TO (c) <u>Hypostatic Pneumonia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>General toxemia due to thrombus of Rt. Femoral</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>5 days.</u> <u>5 days.</u> <u>2 days.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <u>3314</u> 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 <u>24 Sept, 1953</u> , to <u>25 Jan, 1955</u> , that I last saw the deceased alive on <u>25 Jan, 1955</u> , and that death occurred at <u>8:00 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wallace H. Graham, M.D.</u> (Degree or title)				23b. ADDRESS <u>518 Argyle Bldg</u>		23c. DATE SIGNED <u>26 Jan, 1955</u>	
24a. BURIAL CREMATION (REMOVAL) (Specify) <u>Burial</u>		24b. DATE <u>1-27-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lawson Mo.</u>		
DATE REC'D BY LOCAL REG. <u>1-26-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wagner Funeral Home K C Mo.</u>			

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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 *Alvin R. Haunsch*

Licensed Embalmer No. *415*

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.