

FILED OCT 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

33468

4195

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>33 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>St. Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>63 4305 Euclid</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lester</u> b. (Middle) <u>Ferrell</u> c. (Last) <u>Pickering</u>			4. DATE OF DEATH September 27 1955 (Month) (Day) (Year)				
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>April 4 1890</u>	
9. AGE (In years last birthday) <u>65 Yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supervisor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Richland, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Lewis Pickering</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Mollie Pickering</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>488-36-4608</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mollie Pickering - 4305 Euclid</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>Emphysema</u> ANTECEDENT CAUSES <u>Chronic COPULMONARY</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>1953</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>_____</u>					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) (Min.)		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>1-2-54</u> , to <u>9-27-55</u> , that I last saw the deceased alive on <u>9-27-55</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>M. A. Decker M.D.</u>				23b. ADDRESS <u>3299 Kuyper</u>		23c. DATE SIGNED <u>9-28-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>29 Sept 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri.</u>		
DATE REC'D BY LOCAL REG. <u>9-28-55</u>		REGISTRAR'S SIGNATURE <u>neva nichell</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Floral Hills Memorial Chapels K.C. Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

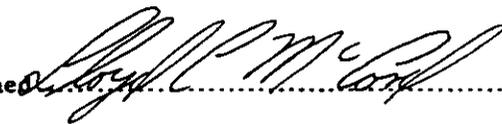
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

B. Atcheson

**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  .....

Licensed Embalmer No. 485.....

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.