

FILED DEC 28 1955

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **40970****5145**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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 LACLEDE													
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY			c. LENGTH OF STAY (in this place) 50 days		c. CITY OR TOWN LEBANON,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>														
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS (If rural, give location) Plato Star Route				D 537													
3. NAME OF DECEASED (Type or Print)			a. (First) EDWARD		b. (Middle) T.		c. (Last) WILLARD														
4. DATE OF DEATH			7. MARRIED, NEVER MARRIED, # WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)														
November 25, 1955			Married		January 23, 1891		64														
5. SEX D		6. COLOR OR RACE White		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)													
Male				Retired farmer				Fayette, Missouri													
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13a. FATHER'S NAME John A. Willard			13b. MOTHER'S MAIDEN NAME Lula Carter			14. NAME OF HUSBAND OR WIFE Daisy												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 500-12-9320			17. INFORMANT'S SIGNATURE OR NAME Official VA Hospital Records, K. C. Mo.															
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)										MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxia										DUE TO (b) Adenocarcinoma of lung										1 day	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.										ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____										12 months	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastases in thoracic spine																				10 1/2	
19a. DATE OF OPERATION										19b. MAJOR FINDINGS OF OPERATION										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) 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 October 6, 1955 , to November 25, 1955 , and that death occurred at 9:15 Am. , from the causes and on the date stated above.																					
23a. SIGNATURE (Degree or title) GLEN G. HALLIDAY, M. D.						23b. ADDRESS VA Hospital, Kansas City, Mo.						23c. DATE SIGNED 11-25-55									
24a. BURIAL CREMATION (Specify)			24b. DATE			24c. NAME OF CEMETERY OR CREMATORY			24d. LOCATION (City, town, or county) (State)												
BURIAL			Nov 25 1955						LEBANON MISSOURI												
DATE REC'D BY LOCAL REG. 11-26-55					REGISTRAR'S SIGNATURE neva Minshall					25. FUNERAL DIRECTOR'S SIGNATURE Dr. Newcomb Jones											
										ADDRESS 1331 BASH CREEK KANSAS CITY, MO.											

(Licensed Embalmer's Statement of Reverse Side)

1956
MAY

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
John B Lewis

Licensed Embalmer No. 4

P. O. Address *Ke w*

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.