

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5135**
Registrar's No. **464**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>464</u>	
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 town(ship)) Kansas City		c. LENGTH OF STAY (in this place) 43 yrs.		c. CITY OR TOWN Kansas City		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 3430 Gillham Road				5. STREET ADDRESS (If rural, give location) 3430 Gillham Road			
3. NAME OF DECEASED (Type or Print) a. (First) LYDIA			b. (Middle)			c. (Last) SPRINGER	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 29, 1956		5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) wid wed	
8. DATE OF BIRTH May 13, 1862		9. AGE (in years last birthday) 93		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) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Chamois - Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samuel Hall		13b. MOTHER'S MAIDEN NAME Sallie Lavender		14. NAME OF HUSBAND OR WIFE John B. Springer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harold E. Stites, 3530 Gillham Rd., K.C. Mo.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic arterio-vascular disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4 days 10 years 4500	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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>1946</u> , 19 <u> </u> , to <u>1/29</u> , 1956, that I last saw the deceased alive on <u>1/27</u> , 1956, and that death occurred at <u>10:00 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE Edward H. Klein (Degree or title) <i>Edward H. Klein</i>				23b. ADDRESS M. D. Piquet Med. Bldg. K.C. Mo.		23c. DATE SIGNED 1/30/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/1/56		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
DATE REC'D BY LOCAL REG. 1-31-56		REGISTRAR'S SIGNATURE <i>Neva Marshall</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO. K.C.MO.			

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

D. S. Edw. H. Klein
Plaza Med. Bldg.

To 1-3150

Exp 10:15 PM

after 1:30 pm.

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 *Robert J. Boy*

Licensed Embalmer No.

P. O. Address *Keokuk*

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.