

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 18 1956

State File No. **13528**
Registrar's No. **1929**

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1929	
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 township) Kansas City		c. LENGTH OF STAY (in this place) 30yrs		c. CITY OR TOWN Kansas City		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 (If not in hospital or institution, give street address or location) 3510 Independence Ave.				STREET ADDRESS (If rural, give location) 3510 Independence Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Blanche			b. (Middle) _____		c. (Last) Thomas		4. DATE OF DEATH (Month) (Day) (Year) March 30, 1956.
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 29, 1892		9. AGE (In years last birthday) 63	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) Cook-Mercy Hospital		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Wisc.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Lewis		13b. MOTHER'S MAIDEN NAME No Record		14. NAME OF HUSBAND OR WIFE William Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Thomas 3510 Independence Ave.			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 7 mo.	
*This does not mean the mode of dying, such as heart failure, asthenia, 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 (b) _____ DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) (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 July, 1955 , to March 30, 1956 , that I last saw the deceased alive on March 29, 1956 and that death occurred at 2:20 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) George F. Clark D.O.				23b. ADDRESS 1329 Broadway		23c. DATE SIGNED 3-30-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 2, 1956	24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Kansas City Mo.		
DATE REC'D BY LOCAL REG. 4-2-56		REGISTRAR'S SIGNATURE neva minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. C.L. Forster Funeral Home Kansas City Mo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
George F. Clark

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.....
J. D. Gilchrist

Licensed Embalmer No. *35*

P.O. Address *K.C.M.*

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.