

FILED FEB 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1554

BIRTH NO. _____		REG. DIST. NO. 146		PRIMARY REG. DIST. NO. 3026		Registrar's No. 37			
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 OR TOWN Independence		c. LENGTH OF STAY (in this place) 3mo		c. CITY OR TOWN Independence		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 12109 E 51st Terr				STREET ADDRESS (If rural, give location) 12109 E 51st Terr					
3. NAME OF DECEASED (Type or Print) Lillian R Son			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH January 29 1957		(Month) (Day) (Year)							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH APRIL 4 1879		9. AGE (In years last birthday) 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) HARTFORD KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE William R. SON (Dec)			
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 DONALD SON 2211 E 67		ADDRESS 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH 10 min.	
				* ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerotic coronary heart disease				5 years	
				DUE TO (c) Chronic cholecystitis				2 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 4201		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) (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 6 Dec, 1956, to 28 Jan, 1957, that I last saw the deceased alive on 11 Jan, 1957, and that death occurred at 9 A. m., from the causes and on the date stated above.									
23a. SIGNATURE Jack M. Davis M.D.				23b. ADDRESS Raytown, Mo.		23c. DATE SIGNED 29 Jan 57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE JAN 30, 1957		24c. NAME OF CEMETERY OR CREMATORY Floral Hills		24d. LOCATION (City, town, or county) (State) Kansas City Missouri			
DATE REC'D BY LOCAL REG. 1-30-57		REGISTRAR'S SIGNATURE L. M. Davis		25. FUNERAL DIRECTOR'S SIGNATURE Sheil Funeral Home		ADDRESS Kansas City Mo			

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

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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 *Thomas A. Shea*

Licensed Embalmer No. *4959*

P. O. Address *J. C. Mc*

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.