

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13460

FILED APR 16 1957

STATE FILE NUMBER

1472

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1472

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, give TOWNSHIP only) Inside Limits OR TOWN <u>KANSAS CITY</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY <u>RAYTOWN</u> 7000 Inside Limits OR TOWN <u>KANSAS CITY</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lake side hosp 2 w b</u> Length of stay in 1b <u>2 w b</u>		d. STREET ADDRESS <u>9412 E. 79th</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>William Falconer Troup</u> First <u>William</u> Middle <u>Falconer</u> Last <u>Troup</u>			4. DATE OF DEATH <u>3-27-1957</u> Month <u>3</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3 - 83</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done <u>RETIRED</u> of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ord Troup</u>			14. MOTHER'S MAIDEN NAME <u>Isabell Falconer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mrs John C. Troup</u> Address <u>LONGVIEW, WASHINGTON</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic myocardial insufficiency</u>	<u>years</u>
	DUE TO (c) <u>Atherosclerosis</u>	<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic carcinoma of the lung</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9:30</u> Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from 1953 to date and last saw ^{her} him alive on 3/27/57
Death occurred at 9:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. R. Lippman, D.O.</u> (Degree or title)	22b. ADDRESS <u>9118 E. 50 Highway</u>	22c. DATE SIGNED <u>3/27/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>MAR-29-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY - MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>3-29-57</u>	26. REGISTRAR'S SIGNATURE <u>Norm Minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

M. R. Lippman

MEDICAL CERTIFICATION



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 *Richard L. Brown*.....

Licensed Embalmer No. *49*

P. O. Address *J.C. Brown*.....

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.