

THE DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17091

FILED JUN 12 1957

STATE FILE NUMBER 2408

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

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) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3427 Aske</u>		Length of stay in lb <u>60 years</u>	d. STREET ADDRESS (If outside, give location) <u>3427 Aske</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>PEARL</u>			4. DATE OF DEATH <u>May 23 1957</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>October 17 1870</u>		
9. AGE (In years last birthday) <u>86</u>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Lima Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Jess Lambough</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Bape</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Mrs Anna Funk - 3427 Aske</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>BRONCHIAL PNEUMONIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					3 YEARS
DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>					YEARS
DUE TO (c) <u>CEREBRAL ARTERIO SCLEROSIS + HYPERTENSION</u>					9
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INF. DECUBITIOUS ULCERS BACK + HINS</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 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 <u>4-21-54</u> to <u>5-23-57</u> and last saw her <sup>him</sup> alive on <u>5-16-57</u> Death occurred at <u>10:25</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree of title) <u>M.D.</u>			22b. ADDRESS <u>4800 E. 24th</u>		22c. DATE SIGNED <u>5-23-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal May 25 1957</u>		23b. DATE <u>May 25 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Lebo Kansas</u>		23e. (State) <u>Kansas</u>			
24. FUNERAL DIRECTOR <u>Hilbert Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>5-24-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

R. S. Long

MEDICAL CERTIFICATION

300  
1-56

Health,  
Welfare  
Public  
Service



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... *Chas E Wilks* .....

Licensed Embalmer No. *264*

P. O. Address *Hemo*

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.