

FILED JUN 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 021357

State File No.

2681

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town or township) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 5 MO. 4 DA.		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 KANSAS CITY TUBERCULOSIS HOSP.		e. STREET ADDRESS (If rural, give location) 417 GLADSTONE PLACE	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) LORENE	b. (Middle) S	c. (Last) SHORT	(Month) JUNE	(Day) 6	(Year) 1957

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH MAY 10, 1916	9. AGE (in years last birthday) 41	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
----------------------	-------------------------------	--	--------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Work	10b. KIND OF BUSINESS OR INDUSTRY Croft Trailer	11. BIRTHPLACE (City and State or Foreign Country) Paola Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A
--	--	--	---

13a. FATHER'S NAME Charles M Seever	13b. MOTHER'S MAIDEN NAME Amanda Humphrey	14. NAME OF HUSBAND OR WIFE _____
--	--	-----------------------------------

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. 487-01-1248	17. INFORMANT'S SIGNATURE OR NAME Mrs Charles Seever	ADDRESS 417 Gladstone Pl
--	--	---	---------------------------------

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY TUBERCULOSIS		INTERVAL BETWEEN ONSET AND DEATH 002X
	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? <input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------	--	---

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 1-2, 1957, to 6-6, 1957, that I last saw the deceased alive on 6-6, 1957, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE Edward P. Altomare M.D.	(Degree or title) M.D.	23b. ADDRESS K. C. T. B. Hosp.	23c. DATE SIGNED 6-6-57
---	-------------------------------	---------------------------------------	--------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) Burial	24b. DATE 6-10-57	24c. NAME OF CEMETERY OR CREMATORY Floral Hills	24d. LOCATION (City, town, or county) (State) KANSAS C.T. MO.
--	--------------------------	--	--

DATE REC'D BY LOCAL REG. 6-7-57	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Sheil Funeral Home	ADDRESS K.C. MO.
--	--	--	-------------------------

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD Edward P. Altomare M.D.

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 *Harold J. [Signature]*

Licensed Embalmer No. *199*

P. O. Address *K. C. [Signature]*

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.