

Health,  
, & Welfare  
S. Public  
th Service

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36178

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4748

5. 300 0  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph Hosp.</b>		Length of stay in 1b <b>17 36 Days</b>	d. STREET ADDRESS (If outside, give location) <b>3735 Locust</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carrie Lee Thomas</b>			4. DATE OF DEATH Month Day Year <b>Oct. 11, 1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1876</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	11. BIRTHPLACE (City and state or country) <b>Grain Valley Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Edmund H. Thomas</b>	13b. MOTHER'S MAIDEN NAME <b>Nancy Miller</b>
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>522-07-6607</b>
17. INFORMANT Address <b>Glen Thomas 3735 Locust K.C. Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive metastatic Carcinoma of</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>left breast</b> DUE TO (c) <b>Smoking</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>170+</b>	
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.) <b>_____</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>_____</b>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>	
20f. CITY, TOWN, OR LOCATION <b>_____</b>		COUNTY STATE	
21. I attended the deceased from <b>Sept 20, 1957</b> , to <b>Oct 11-57</b> and last saw her alive on <b>Oct 11th 1957</b> Death occurred at <b>St Joseph Hospital 10:35 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. H. Kenby M.D.</b>		22b. ADDRESS <b>324 E 11th St ICC Mo</b>	
22c. DATE SIGNED <b>10/14/57</b>		22d. STATE <b>MO. KANS.</b>	
23a. BURIAL CREMATION, REMOVED <input checked="" type="checkbox"/>		23b. DATE <b>10/14/57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City MO. KANS.</b>	
24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b>		ADDRESS <b>K.C. Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>10-14-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
E. N. Gentry.

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.

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Mar. 1-1577 Office  
Pa. 3-5035 Res.  
W. J. Street St. W. York Pa.  
Mon. about 9:30 a.m.

### 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 .....

Signed *E. D. Zippert* .....

Signature of Student Embalmer

Licensed Embalmer No. *4817* .....

P. O. Address *Kennett, Pa.* .....

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.