

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40289

STATE FILE NUMBER

5086

FILED NOV 20 1957

Registration District No. 149 Primary Registration District No. 1005 Registrar's No.

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL		d. STREET ADDRESS 3724 BROADWAY	
3. NAME OF DECEASED (Type or print) First ANNA Middle LUCILE Last DAWSON		4. DATE OF DEATH Month Oct. Day 30 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 30, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) HOUSE WIFE		11. BIRTHPLACE (City and state or country) Knights Town Indiana	
13a. FATHER'S NAME J. H. Cunningham		14. NAME OF HUSBAND OR WIFE RALPH DAWSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and branch of service) NO		17. INFORMANT RALPH DAWSON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Intestinal Obstruction DUE TO (c) Papillary Adeno-Carcinoma of Uterus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to a terminal disease as given in Part I (a) with metastases to right lung and tube		INTERVAL BETWEEN ONSET AND DEATH 10/23/57 10/28/57 1956	
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.) 1947	
20c. TIME OF INJURY Hour _____ 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 June 28, 1957 to October 30, 1957 and last saw her alive on October 30, 1957 . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Lyle G. Willits (Degree or title) M.D.	
22b. ADDRESS 1103 Grand Ave.		22c. DATE SIGNED 10/31/57	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-1-57	23c. NAME OF CEMETERY OR CREMATORY White Chapel mem. Park, Wichita, Kans.	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR D. CO. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 11-1-57	
26. REGISTRAR'S SIGNATURE Reva Trinschall			

(Licensed Embalmer's Statement on Reverse Side)

Lyle G. Willits USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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.

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 *Dern Lawler*

Licensed Embalmer No. *4915*

P. O. Address *47 E 32nd St*

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.