

pt. Health,  
, & Welfare  
S. Public  
alth Service

S. 300  
ev. 1-57

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.  
Securing the medical certificate in the specific manner required by 1921.140 MO. REV. 1927.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44466  
STATE FILE NUMBER  
REGISTRAR'S NO. 5700

FILED DEC 18 1957

Registration District No. 149 Primary Registration District No. 1002

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) <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 <u>EIMS NURSING HOME</u> INSTITUTION <u>1318 E. ARMOUR BLVD</u>			Length of stay in lb <u>50 years</u>		d. STREET ADDRESS (If outside, give location) <u>2718 East 67th Street</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>LORIMER</u> Last <u>LORIMER</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</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>Oct. 2, 1882</u>			
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Postal Inspector</u>		11. BIRTHPLACE (City and state or country) <u>Collyer, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Dept.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Dept.</u>		11. BIRTHPLACE (City and state or country) <u>Collyer, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>William Lorimer</u>			13b. MOTHER'S MAIDEN NAME <u>Anne Turnbull</u>			14. NAME OF HUSBAND OR WIFE <u>Catherine Lorimer</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>R. J. Lorimer</u>			Address <u>2718 East 67th Street Kansas City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumo-pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchogenic Carcinoma</u>							8 mos.		
DUE TO (c) <u>Cryptococcosis</u>							162x		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cryptococcosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> WORK <input type="checkbox"/> 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>3/19/52</u> to <u>11/29/57</u> and last saw <sup>her</sup> him alive on <u>11/29/57</u> Death occurred at <u>7:45 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Type or print) <u>Joseph A. Fogarty M.D.</u>				22b. ADDRESS <u>5811 Truman Blvd. #25 Mo</u>		22c. DATE SIGNED <u>11/30/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC. 2, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>			
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>				25. DATE RECD. BY LOCAL REG. <u>12-2-57</u>		26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>			

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Joseph A. Fogarty

AD 34404 - 71-10-16 3:30 PM



*Cryptococcus*

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 *Raymond M. Hardy* .....

Licensed Embalmer No. *4913* .....

P. O. Address *Indep, Mo.* .....

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.