

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025628

STATE FILE NUMBER

FILED JUL 30 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3504

S. 300
1-57 0
3

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>P.O.A. TRINITY LUTHERAN HOSP.</u>		Length of stay in 1b <u>43 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>225 EAST 74th TERR</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORIS MAY LEMBKE</u>			4. DATE OF DEATH Month Day Year <u>July 16, 1958</u>
5. SEX <u>FEMALE</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. 31, 1900</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9c. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>57</u> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	10c. BIRTHPLACE (City and state or country) <u>Mystic, Iowa</u>
11. BIRTHPLACE (City and state or country) <u>Mystic, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>SAMUEL C. MCKINLAY</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH GORDON</u>	14. NAME OF HUSBAND OR WIFE <u>GEORGE LEMBKE</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>489-22-9286</u>	17. INFORMANT Address <u>GEORGE LEMBKE, 225 E. 74th TERRACE</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>Acute Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4201</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>7/16/58 8:30 PM to 9:30 PM 7/16/58</u>
21. I attended the deceased from <u>8:30 PM</u> to <u>9:30 PM</u> and last saw her alive on <u>7/16/58</u> Death occurred at <u>9:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. J. Farnsworth M.D.</u>		22b. ADDRESS <u>1103 Grand K.C. Mo.</u>	22c. DATE SIGNED <u>7/17/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>July 19, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT MORIAN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR ADDRESS <u>D.W. NEWCOMER'S SONS-K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>7-18-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

J. J. Farnsworth 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.



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 *Vern Lawler*

Licensed Embalmer No. *4915*

P. O. Address *KC 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.