

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033201  
STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 213

FILED OCT 15 1958

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>RURAL PRAIRIE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY 3528</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>JACKSON Co. Hosp.</u> Length of stay in 1b <u>3 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>3429 FLORA</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lida</u> Middle <u>PEARL</u> Last <u>Symonds</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1958</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1 - 1878</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Winchester, Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>James Lewis Allan</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Hart</u>	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) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-26-3899</u>	17. INFORMANT <u>Frank Allan</u> Address <u>3439 F. Lang Ave K.C. Mo.</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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>Myocardial infarction</u> <u>332X</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"/> 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 9-8-55 to 10-8-58 and last saw her alive on 10-7-58  
Death occurred at 6:40 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>W. R. Newcomer, Jackson Co. Hosp. Indep. Mo.</u>	22c. DATE SIGNED <u>10-10-58</u>
---	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 10 - 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>
---	--------------------------------	--	---

24. FUNERAL DIRECTOR <u>D.W. Newcomer</u> ADDRESS <u>1331</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-1958</u>	26. REGISTRAR'S SIGNATURE <u>N.B. Langford</u>
---	---	--

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.

300  
1-57

30

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 *Chester K. Brown*.....

Licensed Embalmer No. *4931*.....  
P. O. Address *K.C. 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.