

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044076
STATE FILE NUMBER
6015

FILED JAN 9 1959

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

300
1-57

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>Europe Park Shelter #2</u>		Length of stay in 1b <u>18 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>7619 Wabash</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>T.</u> Last <u>Dolaney</u>			4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>58</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1931</u>
9. AGE (In years last birthday) <u>27</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Nat Bank</u>	11. BIRTHPLACE (City and state or country) <u>Chillicothe Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Charles E. Dolaney</u>	
13b. MOTHER'S MAIDEN NAME <u>Frances Bates</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>490-34-9506</u>	17. INFORMANT <u>Chas. E. Dolaney</u> Address <u>Same</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>Bursting blood of</u> DUE TO (b) <u>Left side of chest</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </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.) <u>apparently shot herself</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>12-18-58</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Wash</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>	
20g. COUNTY <u>Jackson</u>		20h. STATE <u>Mo</u>	
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Geo. C. Kealhofer</u> (Degree or title) _____		22b. ADDRESS <u>6627 Prospect Ave</u>	
22c. DATE SIGNED <u>12-19-58</u>		22d. _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-20-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laclede Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Laclede Mo</u>
24. FUNERAL DIRECTOR <u>B. E. Wulbert</u> ADDRESS <u>K.C. MO</u>		25. DATE RECD. BY LOCAL REG. <u>12-20-58</u>	26. REGISTRAR'S SIGNATURE <u>never Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Geo. C. Kealhofer

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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 *B. E. Willet*

Licensed Embalmer No. *4095*
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.