THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001401

STATE FILE NUMBER 253

FILED JAN 28 1959

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

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): KANSAS CITY, MO. — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 1313 EUCLID — Length of stay in 1b: 18 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY, MO. — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1313 EUCLID — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: LULA Middle: ANN Last: LEWIS

4. DATE OF DEATH: Month 1 Day 11 Year 59

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 4-15-92

9. AGE (In years last birthday): 66 — 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): PENTIONER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): MORRILTON ARK.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JOHN HOWELL

13b. MOTHER'S MAIDEN NAME: LYDIA JAMESON

14. NAME OF HUSBAND OR WIFE: TOM LEWIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: none

17. INFORMANT: JOHN HOWELL LEWIS — Address: 1315 EUCLID

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronchial Asthma - Senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 _____, 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 (Degree or title): Deputy Coroner — Hollman M.D.

22b. ADDRESS: 1618 Lydia Ave

22c. DATE SIGNED: 1/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1-15-59

23c. NAME OF CEMETERY OR CREMATORY: BLUERIDGE LAWN

23d. LOCATION (City, town, or county) (State): Kansas City, Mo

24. FUNERAL DIRECTOR ADDRESS: Sterling Kilbr 212 Vine

25. DATE RECD. BY LOCAL REG.: 1-15-59

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed E. Sterling Bu

Licensed Embalmer No. 3178

P. O. Address 1212 Au

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.