

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009506

STATE FILE NUMBER

FILED MAR 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1046

300
-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) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jackson county</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Northwest Osteopathic</u>		Length of stay in 1b <u>3 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>9709 E 81st Terr</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Goldie</u> Last <u>Lakin</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1959</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"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20, 1889</u>
9. AGE (In years last birthday) <u>69</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) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>West plains, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Upson Pence</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Key</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM R. LAKIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>497-26-1910</u>	17. INFORMANT Address <u>1817 Lister</u> <u>Lawrence Lakin Kan. City 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>Pneumonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Perforated Gangrenous Gall Bladder</u>			
DUE TO (c) <u>Cholecystitis & Cholelithiasis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5'</u>			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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Death occurred at <u>Feb 17, 1959</u> to <u>Feb 23, 1959</u> and last saw her <u>alive on Feb 23, 1959</u> <u>6:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or title) <u>Frank E. Day D.O.</u>		22b. ADDRESS <u>4314 89th K.C. Mo.</u>	22c. DATE SIGNED <u>2-25-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
24. FUNERAL DIRECTOR <u>Muehlebach Kan. City Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-25-59</u>	26. REGISTRAR'S SIGNATURE <u>Gene Marshall</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

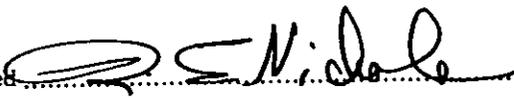
Frank E. Day

4314 E 92
Be 1-0162
Ch. 1-4693 Home
Ch. 1-3434

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 

Licensed Embalmer No. 4997
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.