

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013580

FILED APR 20 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 1603

00
57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Length of stay in 1b 2 yrs.	d. STREET ADDRESS (If outside, give location) 706 E. 55th Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Louella E. Thomas			4. DATE OF DEATH Month Day Year Mar. 27, 1959		
--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1876	9. AGE (In years at birthday) 80 82	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) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Aurora, Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	-----------------------------------	---	---

13a. FATHER'S NAME Lucius P. Dieterich	13b. MOTHER'S MAIDEN NAME Lydia Schmall	14. NAME OF HUSBAND OR WIFE Arthur W. Thomas
--	---	--

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 L. A. Thomas, Wichita, Kansas
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Adrenal Insufficiency, Azotemia, Anemia		INTERVAL BETWEEN ONSET AND DEATH 3 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cholecystitis, Chronic, Acute, Cholelithiasis, Common Duct Obstruction 10 Days	Years
	DUE TO (c) Atherosclerosis, Renal, Generalized. 584+	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cholecystectomy Cholecholestomy March 26th 1959		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 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 12-30-57 to 3-27-59 and last saw her alive on 3-27-59 Death occurred at 8:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Terry E. Lilly, Jr. M.D.	22b. ADDRESS 915 Argyle Building	22c. DATE SIGNED 3/28/59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 29, 1959	23c. NAME OF CEMETERY OR CREMATORY Spring Lake	23d. LOCATION (City, town, or county) (State) Aurora, Illinois
---	-----------------------------------	--	--

24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 3-28-59	26. REGISTRAR'S SIGNATURE Neva Marshall
--	--	---

Terry E. Lilly USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION ALL diseases in Part I must be causally related.

12:30 p.m.

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 *Joe B Yoder*

Licensed Embalmer No. *4173*
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.