

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017628  
STATE FILE NUMBER  
2116

FILED MAY 21 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2116

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2818 Kensington</b>		d. STREET ADDRESS (If outside, give location) <b>2818 Kensington</b>	
Length of stay in lb <b>3 Yrs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucinda</b> Middle <b>Buchanan</b> Last <b>Buchanan</b>			4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1899</b>
9. AGE (In years last birthday) <b>60</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Lexington, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Abbie H. White</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Belle</b>	14. NAME OF HUSBAND OR WIFE <b>James Buchanan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) (If yes, give dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Lorene Washington 2818 Kensington</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 or 4 days</b>
DUE TO (b) <b>Hypertensive Cardio Vascular Disease</b>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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.) <b>443X</b>
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 <b>April 22, 1959</b> to <b>April 25, 1959</b> and last saw her alive on <b>April 25, 1959</b> Death occurred at <b>3:40 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>George H. Taft, M.D.</b>		22b. ADDRESS <b>2204 E. 18th St. St.</b>	22c. DATE SIGNED <b>4/27/59</b>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <b>4-30--59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Lexington, Mo.</b>
24. FUNERAL DIRECTOR <b>Lawrence A. Jones</b>		ADDRESS <b>2304 Vine</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-59</b>
			26. REGISTRAR'S SIGNATURE <b>Walter Minshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

George H. Taft



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 *Lawrence A. Jones*

Licensed Embalmer No. *4420*

P. O. Address *2364 Elm*

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.