

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 12 1959

59-024522

STATE FILE NUMBER

Registration District No. 13 Primary Registration District No. 5291 Registrar's No. 94

| | | | |
|---------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Platte</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Liberty, Mo.</u> | | Length of stay in 1b <u>6 Weeks</u> | c. CITY OR TOWN <u>Parkville, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>I.O.O.F. Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Route 5 Box 420</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| | | | | |
|--------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Vernon</u> Last <u>Lacy</u> | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1959</u> | |
|--------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|

| | | | | | | |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-14-1879</u> | 9. AGE (last birthday) <u>79</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stationary Eng.</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u> | 11. BIRTHPLACE (City and state or country) <u>Brookville, Indiana</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------|

| | | |
|-----------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| 13a. FATHER'S NAME <u>Issac Lacy</u> | 13b. MOTHER'S MAIDEN NAME <u>Susan Jeter</u> | 14. NAME OF HUSBAND OR WIFE <u>Josie M. Lacy</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>91-996-167</u> | 17. INFORMANT Address <u>Mrs. Vernon Kinkade 5119 Woodland K.C., 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>Pneumonia, Broncho, Acute</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ | |
| | DUE TO (c) _____ | |

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Arteriosclerosis with cerebral vascular Accident</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| | | |
|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 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 1955 to 8-1-59 and last saw her/him alive on 8-1-59.
Death occurred at 4 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--------------------------------------------------------------------|------------------------------------------------|-----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Donald E. Kierszki M.D.</u> | 22b. ADDRESS <u>8400 N Oak Hwy K.C. Mo.</u> | 22c. DATE SIGNED <u>8-1-59</u> |
|--------------------------------------------------------------------|------------------------------------------------|-----------------------------------|

| | | | |
|------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 3, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>East Slope Mem. Gardens</u> | 23d. LOCATION (City, town, or county) (State) <u>Riverside, Mo.</u> |
|------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------------|

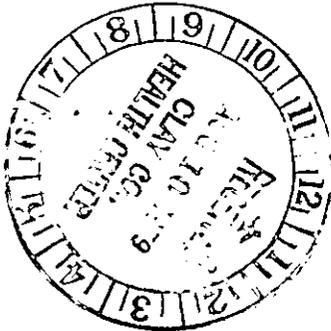
| | | | |
|-----------------------------------------------------|------------------------------------------|-----------------------------------------------|----------------------------------------------|
| 24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons</u> | ADDRESS <u>North Kansas City, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>8-5-59</u> | REGISTRAR'S SIGNATURE <u>Mabel Graham</u> |
|-----------------------------------------------------|------------------------------------------|-----------------------------------------------|----------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John H. Kalsbeek

Licensed Embalmer No. 494

P. O. Address Mo. Kansas

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.