

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025250

FILED VS JUL 27 1959 49

Primary Registration District No. 1002

Registrar's No. 3422

STATE FILE NUMBER

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>		Length of stay in 1b <b>27 Yrs. 53</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>700 East 97th St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3629 Troost Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Polly</b> Middle <b>Lazell</b> Last <b>Lazell</b>			4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ravanna, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Hollingsworth</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Bruce</b>		14. NAME OF HUSBAND OR WIFE <b>LEWIS LAZELL</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>494 14 5116</b>		17. INFORMANT <b>Mrs. Mildred Fitzgerald 700 E. 97th St</b> Address <b>K.C.MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b>					<b>3 mos.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Sigmoid Colon</b>					<b>6 mos</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)					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 <b>p.m.</b> 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 <b>MARCH 10, 1958</b> <b>July 10, '59</b> and last saw <b>her</b> alive on <b>July 8, '59</b> . Death occurred at <b>11:45 PM 240759 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>[Signature]</b> Degree or title <b>M.D.</b>			22b. ADDRESS <b>4526 PAREO, K.C. Mo</b>		22c. DATE SIGNED <b>7-13-59.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JULY 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>08B FELLOWS CEM</b>		23d. LOCATION (City, town, or county) (State) <b>ST. JOSEPH MO.</b>		
24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons Kansas City, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-13-59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

DOCUMENT

BY AFFIDAVIT OF Claude C. Farley M.D. MEDICAL CERTIFICATION

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 Marvin D. Preston

Licensed Embalmer No. 5040

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.