

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029153

Registration District No. 4 1959 149 Primary Registration District No. 1002 Registrar's No. 4105 STATE FILE NUMBER

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) Kansas City		Length of stay in 1b 40 yrs.		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 Menorah Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1662 Oakley			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Beulah Middle M. Last Lawrence				4. DATE OF DEATH Month August Day 22 Year 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 3-11-03	9. AGE (last birthday) 56	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) Packer			10b. KIND OF BUSINESS OR INDUSTRY Cake Box Bakery		11. BIRTHPLACE (City and state or country) Joplin, Missouri		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Jacob Rhodes			13b. MOTHER'S MAIDEN NAME Josephene Green			14. NAME OF HUSBAND OR WIFE John R. Lawrence Sr.			
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. 495-20-4390		17. INFORMANT Rose Gresham		Address 5432 E. 17th St.		
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) Carcinoma of ampulla with metastases to liver cirrhosis of liver							7 Months		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. acute peritonitis							1 wk.		
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 checked="" type="checkbox"/> NO <input 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 8-11-59 to 8-22-59 and last saw her/him alive on 8-22-59 . Death occurred at 3:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) B. Marcus Keller M.D.				22b. ADDRESS 409 S. 63rd			22c. DATE SIGNED 8-23-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri				
24. FUNERAL DIRECTOR Earp & Sons 4707 Truman Rd. K. C. Mo.			25. DATE RECD. BY LOCAL REG. 8-24-59		26. REGISTRAR'S SIGNATURE Reva Munchall				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

B. Marcus Keller

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 William H. Camp

Licensed Embalmer No. 4728

P. O. Address H.C.

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.