

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032438

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4254 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) OR TOWN Kansas City | | Length of stay in 1b 25 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 Nora-Rae Rest Home | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 501 West 13th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LENA Middle May Last LANCASTER | | | | 4. DATE OF DEATH Month August Day 25 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 May 2 1868 | 9. AGE (last birthday) 91 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Alabama | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME William Martin | | | 13b. MOTHER'S MAIDEN NAME No Record | | | 14. NAME OF HUSBAND OR WIFE Charlie Lancaster | | |
| 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 Homer Taylor | | | Address Same |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 years | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis | | | | | | | 8 years | |
| 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 _____ 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 5-29-59 to 8-25-59 and last saw her/him alive on 8-25-59 Death occurred at 7:55 pm on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE Frank Paul Lawrence M.D. (Degree or title) | | | | 22b. ADDRESS 428 S. White Ave | | | 22c. DATE SIGNED 8-25-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-2-59 | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill | | 23d. LOCATION (City, town, or county) Kansas City, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Weilert's: 6900 Troost: F.C. Mo. | | | | 25. DATE RECD. BY LOCAL REG. 9-1-59 | | 26. REGISTRAR'S SIGNATURE new Marshall | | |

DOCUMENT

BY AFFIDAVIT OF Frank Paul Lawrence 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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.