

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-02326*8

FILED VS JUL 5 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3213 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 Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 501 West 31st Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Emily Middle R. Last Lindbloom			4. DATE OF DEATH Month June Day 16 Year 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-5-1895	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Osage City, Kansas	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Charles Lindbloom	13b. MOTHER'S MAIDEN NAME Bena Pierson	14. NAME OF HUSBAND OR WIFE _____
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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 Mrs. Helen Huffman, Osage City, Kansas	Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 5 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Primary site not determined	
	DUE TO (c) Proven by study of pleural fluid cells.	
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.) _____
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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 _____
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21. I attended the deceased from **April 6, 1960** to **June 16, 1960** and last saw him alive on **June 15, 1960**.
Death occurred at **1:05 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William F. Sanders M.D. (Degree or title)	22b. ADDRESS 411 Nichols Rd. Kansas City, Mo.	22c. DATE SIGNED 6/16/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-18-60	23c. NAME OF CEMETERY OR CREMATORY Rapp Cemetery	23d. LOCATION (City, town, or county) Osage City, Kansas	(State) _____
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar, ADDRESS 20 West Linwood Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 6-17-60	26. REGISTRAR'S SIGNATURE Neva Marshall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

William F. Sanders

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

Wm H. Gentry

Licensed Embalmer No. 503

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.