

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023274

FILED VS JUN 30 1960

149

Primary Registration District No. 1002

Registrar's No.

3149

STATE FILE NUMBER

ENDED

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 36 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 ST. LUKES Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6436 E. 16th ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IRVING Middle W. Last LUNCEFORD			4. DATE OF DEATH Month 6 Day 11 Year 1960			
5. SEX MALE	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH SEPT 4-1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY UNION WIRE & ROPE		11. BIRTHPLACE (City and state or country) OAK GROVE, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A
13a. FATHER'S NAME William Lunceford		13b. MOTHER'S MAIDEN NAME ELLA HAWES		14. NAME OF HUSBAND OR WIFE Cecille Lunceford		
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. 487 03 1196		17. INFORMANT Address Mrs Cecille Lunceford 6436 E 16th K.C. MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral vascular insufficiency DUE TO (c) Left middle cerebral artery thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral atherosclerosis 10 yrs 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						INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 d 3 d
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 Month, Day, Year a.m. p.m.		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 Jan 8 1960 to present and last saw her/him alive on 6-11-60 Death occurred at 12:55 Am on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Geo. K. Boyd MD			22b. ADDRESS 5111 Indep Ave KC Mo		22c. DATE SIGNED 6/13/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-13-1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR ADDRESS Floral Hills Memorial Chapel Inc K.C. Mo		25. DATE RECD. BY LOCAL REG. 6-13-60	26. REGISTRAR'S SIGNATURE Neva Trinchall			

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 Forrest D. Goldsman

Licensed Embalmer No. 4714

P. O. Address 1004 W

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.