

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038828

149

1002

5387

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 1 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City	a. STATE Missouri	b. COUNTY Jackson
Length of stay in 1b 2 1/2 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		d. STREET ADDRESS (If outside, give location) 2423 Tracy	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First Middle Last Amanda E Lucas	Month Day Year October 21 1962

5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-27-02	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sweet Spring, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Everett Johnson	13b. MOTHER'S MAIDEN NAME Elizabeth Brown	14. NAME OF HUSBAND OR WIFE Harry Lucas
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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	17. INFORMANT Address Menorah Medical Center K. C. Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:	3 months
IMMEDIATE CAUSE (a) Carcinomatosis.	
DUE TO (b) Carcinoma of ovary.	4 months
DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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 September 1962 to October 21 1962 and last saw her ^{her} alive on October 21, 1962 Death occurred at 4:10 P. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Walter Harvey Jacobs, M.D.	22b. ADDRESS 751-E 63RD St. Kansas City, Mo.	22c. DATE SIGNED 10/30/62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/24/62	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn Cem.	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Mrs. Meek's Mortuary K. C. Mo.	25. DATE RECD. BY LOCAL REG. 10-23-62	26. REGISTRAR'S SIGNATURE Ruth Long
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VS 300 Rev. 4/59

1

2 **2418**

3

4 **3**

5 **1**

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7 **0**

8 **1**

9 **1750**

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11

12 **61-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Walter Harvey Jacobs MEDICAL CERTIFICATION

USE BLACK INK OR OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Millard B Perkins

Licensed Embalmer No. 5013

P. O. Address A. C. 7th

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.