

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028120

4183

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4183

FILED AUG 14 1963

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1					
2 <u>3x58</u>					
3					
4 <u>1</u>					
5 <u>1</u>					
6					
7 <u>0</u>					
8 <u>1</u>					
9 <u>201X</u>					
10					
11					
12 <u>65-0</u>					
13					
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF				
ITEM NO.	SHOULD READ				

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION  
H. R. Lyndon, Jr.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>37 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7005 East 103rd Ter.</b>
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>A.</b> Last <b>ASTRY</b>			4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH. <b>12-27-1925</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>37</b>
11a. FATHER'S NAME <b>Roger W. Lister, Sr.</b>		11b. MOTHER'S MAIDEN NAME <b>Mary Helen Twining</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		12b. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <b>Clyde Edward Astry</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Clyde Edward Astry</b> Address <b>Kansas City, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Complicated by aplastic Anemia</u>			<u>4 mo.</u>
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 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.		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 <u>12:50 P</u> to <u>7-24-63</u> and last saw her/him alive on <u>7-24-63</u> . Death occurred at <u>11:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. R. Lyndon, Jr.</u>		(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>1027 E. 75, KC MO</u>
22c. DATE SIGNED <u>7-26-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-27-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b> ADDRESS <b>Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-26-63</b>	26. REGISTRARS SIGNATURE <u>[Signature]</u>

FR. LYNN

1027 E. 75TH

10-12

1:30 - 4:30

EX 284

1-1-0-1

0-22

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 *J. P. Freeman*

Licensed Embalmer No. 2939

P. O. Address F. O. Mo.

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.