

DEC 22 1941

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 4335

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3922 Windsor
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 Years
 In this community 12 Years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3922 Windsor
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME LUCINDA ELLEN WOOLLOMES

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Fe. 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Jesse M. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 2, 1854
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 2 18 hr. _____ min.

9. Birthplace Rawls Co., Unknown
 (City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Lucinda Hitch
William Stears

13. Birthplace Unknown
 (City, town, or county) (State or foreign country)

14. Maiden name Lucinda Hitch

15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Estil Dunn

(b) Address 3922 Windsor

17. (a) Burial (b) Date thereof 11-22-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington cemetery

18. (a) Signature of funeral director C. H. BLACKMAN & SON, INC.

(b) Address 2825 Indep. Blvd. Kansas City, Mo.

19. (a) 11-22-41 (b) M. M. Crow
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
 year 1941 hour 1 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 1929
 19 _____ to Nov. 20 - 1941;

that I last saw h. alive on Nov. 19 - 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Congestion

Due to Hypostatic Pneumonia

Due to senility
senile dementia

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature Earl W. Lewis (M. D. or other) D. S.
 Address 100 1/2 S. Polk Date signed 11-21-41

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

22-2
13-10
11-150

Dr Jones, 100 1/2 Avenue

13

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Walter L. Kestey

Licensed Embalmer No.

4225

P. O. Address.....

Indes, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF HEALTH OFFICERS

o. 2
4-41
7-39
X29484

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No.....

Primary Registration District No.....

Registrar's No. **4335**

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3922 Windsor
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Lucinda Ellen Woollomes**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **Nov.** day **20**
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

Immediate cause of death
Pulmonary congestion

Due to **Hypostatic pneumonia Broncho.**

Due to **Senility**

Other conditions.....
(Include pregnancy within 3 months of death)

107a

8. AGE: Years **87** Months..... Days..... If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county)..... (State or foreign country).....

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county)..... (State or foreign country).....

14. Maiden name.....

15. Birthplace..... (City, town, or county)..... (State or foreign country).....

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation.....)

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) **12/31/41** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
..... (Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature **Earl J. [unclear]** (M. D. or other).....
Address..... Date signed.....

WRITE PLAINLY—USE UNFADING INK

PERMANENT RECORD

S-37540

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37540
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Assass City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of Hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Leunda C. Wallames
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 Day 2 Year 1954 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 2, 1854
(Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days _____ (If less than one day)
hr. min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

Immediate cause of death Pulmonary embolism
pneumonia
Due to Pulmonary embolism
embolization

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ 107
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Earl J. Jones (M. D. or other) Co.
Address 100 1/2 S. Baker Date signed 1-12-54

SUPPLEMENTARY 20

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

BLACK INK—MAKE

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.