S. No. 2
DM—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1943

Registration District No.

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No. 30977

Registrar's No. 4116

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Children's Mercy Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days, 3 hrs. 55 min (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 3112 Bell Kansas City
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Spick, Lillie Mabel

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 18 1943
(Month) (Day) (Year)

8. AGE: Years 0 Months 7 Days 5 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Jacob Spick
13. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ida Bell Calloway
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Spick
(b) Address 3112 Bell

17. (a) Burial
(Burial, cremation, or removal)
(b) Date thereof Sept 27 43
(Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Wm C L Forster
(b) Address 918 Brooklyn

19. (a) 9-28-43
(Date received local registrar)
(b) T E Brown Dep
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 23
year 43 hour minute 10 55 P.M.

21. I hereby certify that I attended the deceased from 9-19, 1943, to 9-23, 1943
that I last saw her alive on 9-23, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Post Mortem	
Due to: Athrepsia	
Emaciation 8	
Due to: Dehydration 10	
Dilatation of heart	
Other conditions (Include pregnancy within 3 months of death): Passive congestion	
Major findings: Of operations: Viscera	
Of autopsy	

PHYSICIAN
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 0

23. Signature John H Gaskin M.D.
(M. D. or other)
Address Mercy Child. Hosp. Date signed 9-24-43

(Licensed Embalmer's Statement on Reverse Side)

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 me

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 2570 Mo

P. O. Address Memo

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