

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5165

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 602

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> | |
| c. LENGTH OF STAY (in this place) <u>30 yrs.</u> | | d. STREET ADDRESS (If rural, give location) <u>2623 Kensington</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u> | | | |

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|--|----------------------------------|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Lydia</u> b. (Middle) <u>FRANCES</u> c. (Last) <u>Trainor</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>2 7 1949</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>August 29, 1858</u> | 9. AGE (In years last birthday) <u>90</u> | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME <u>W. H. FLESHER</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY ANN BOYLAN</u> | | 14. NAME OF HUSBAND OR WIFE <u>J. M. TRAINOR</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. M. DEPEW LINCOLN CALIF.</u> | |

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|---|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> |
| | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|--|--|--|--|---|---|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR | |

22. I hereby certify that I attended the deceased from Jan. 26, 1949 to Feb. 7, 1949, that I last saw the deceased alive on Feb. 7, 1949, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

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|---|--|---|--|--|--|
| 23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title) | | 23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u> | | 23c. DATE SIGNED <u>2-8-49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 24b. DATE <u>2-10-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE</u> | |
| DATE REC'D BY LOCAL REG. <u>2-9-49</u> | | REGISTRAR'S SIGNATURE <u>Eveline Holmes</u> | | 24d. LOCATION (City, town, or county) (State) <u>TRENTON - MISSOURI</u> | |
| | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. BLACKMAN & SON, INC.</u> | | ADDRESS <u>K.C., Mo.</u> | |

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

Dr. Porter

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.

Signed *O. K. McFarland*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4397*.....

P. O. Address *Kansas City*.....

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.