FILED SEP 2 1950

STANDARD CERTIFICATE OF DEATH

State File No. 27128

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3519

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): 12 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital No. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
d. STREET ADDRESS (If rural, give location): 3540 Central

3488

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): H.
c. (Last): Squarey

4. DATE OF DEATH (Month) 8 (Day) 15 (Year) 50

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 20, 1881
9. AGE (In years last birthday): 69 — 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): Retired Storekeeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: Robert Squarey
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Mrs. Lucille M. Squarey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Lucille M. Squarey, 3540 Central

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid 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 [X] NO [ ]

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 [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 17, 1950, *to* Aug. 15, 1950, *that I last saw the deceased alive on* Aug. 15, 1950, *and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B.I.Burns [signature] M.D.
23b. ADDRESS: 24th & Cherry
23c. DATE SIGNED: 8-15-50

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 5
24b. DATE: 8-16-50
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): Davenport, Iowa

DATE REC'D BY LOCAL REG.: 8-16-50
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Freeman Mortuary Kansas City, Missouri

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Willis H Bennett

Licensed Embalmer No. 4438

P. O. Address H.C. Mc

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

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