

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED FEB 9 1953

BIRTH NO. _____ REG. DIST. NO. **20** PRIMARY REG. DIST. NO. **4031** Registrar's No. **76**

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Adrian		c. LENGTH OF STAY (In this place) 2 day	
d. FULL NAME OF HOSPITAL OR INSTITUTION 24 Ohio St		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City 3568	
		d. STREET ADDRESS (If rural, give location) 3830 Chestnut 1	
3. NAME OF DECEASED (Type or Print) a. (First) Lydia b. (Middle) Jane c. (Last) Willsey			4. DATE OF DEATH (Month) (Day) (Year) 2-2-53
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan 9-1867
9. AGE (In years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	11. BIRTHPLACE (City and State or Foreign Country) Greenwood Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Home	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Samuel Hager		13b. MOTHER'S MAIDEN NAME Margaret Cramer	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME John W Willsey ADDRESS Kansas City Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) ADMISSION - 3 chloroform Barbital hypodermic		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) above DUE TO (c) 331 X	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			
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) _____	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 Feb 1 , 19 53 , to Feb 2 , 19 53 that I last saw the deceased alive on Feb 2 , 19 53 , and that death occurred at 4:00 P. m., from the causes and on the date stated above.			
23a. SIGNATURE E. F. Robinson M.D. (Degree or title)		23b. ADDRESS Adrian Mo	23c. DATE SIGNED 2-2-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/4/53	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) Greenwood Mo
DATE REC'D BY LOCAL REG. 2-4-53	REGISTRAR'S SIGNATURE Myra Owens	25. FUNERAL DIRECTOR'S SIGNATURE N B Longford Geo Summit ADDRESS Mo	

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

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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

Student Embalmer

Signed

W B Langford

Licensed Embalmer No. *3835*

P. O. Address *Lee's Summit*

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.