

FILED<sup>SD</sup> APR 9 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

9689

1578

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1578</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Anderson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>7 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kincaid</u>		950	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Osteopathic Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lucile</u> b. (Middle) _____ c. (Last) <u>Arn</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 16, 1953</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-9-1896</u>		9. AGE (In years last birthday) <u>56</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>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David Mc Fann</u>		13b. MOTHER'S MAIDEN NAME <u>Ida May Galispie</u>		14. NAME OF HUSBAND OR WIFE <u>Buford Arn</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>No</u>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <u>Buford Arn Kincaid Kansas</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u> ANTECEDENT CAUSES DUE TO (b) <u>Nephritis (chronic)</u> DUE TO (c) <u>Surgical shock</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hepatitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 1/2</u>
19a. DATE OF OPERATION <u>3-10-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Rectum</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>3-9</u> , 1953, to <u>3-16</u> , 1953, that I last saw the deceased alive on <u>3-15</u> , 1953, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H. J. Mc Anally</u> (Degree or title) _____				23b. ADDRESS <u>926 E. 11th K.C. Mo</u>		23c. DATE SIGNED <u>3-16-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/16/53</u>		24c. NAME OF CEMETERY OR CREMATORY: _____		24d. LOCATION (City, town, or county) (State) <u>Kincaid Kans.</u>	
DATE REC'D BY LOCAL REG. <u>3-19-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE, Kansas City, Mo.</u>			

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.

Signed.....  
Student Embalmer

Student Embalmer No.....

Signed

*[Handwritten Signature]*  
Licensed Embalmer No. 1415  
P. O. Address 130 4th

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.