

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18335

FILED MAY 27 1953

State File No. 2374

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>2374</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
a. COUNTY <u>Jackson</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>6 mo</u>		a. STATE <u>Missouri</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>300 Benton, Conn.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>5820 Highland</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) <u>Lucy</u>		b. (Middle) <u>Hafford</u>	c. (Last) <u>Winslow</u>		Month <u>May</u>	Day <u>5</u>	Year <u>1953</u>
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 30 1890</u>		9. AGE (In years last birthday) <u>62</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Carrollton, Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>Ebenezer Hafford</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Malcolmson</u>
14. NAME OF HUSBAND OR WIFE <u>DECEASED</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 <u>Mrs. Mildred Lucy</u>	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia, Acute Hypostatic</u>				<u>2 days</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				DUE TO (b) <u>Atelectasis left lung due to Mucus plug</u>	
		DUE TO (c) <u>General & Cerebral Arteriosclerosis</u>				<u>5 Years</u>	
		II. OTHER SIGNIFICANT CONDITIONS				<u>334X</u>	
		Conditions contributing to the death but not related to the disease or condition causing death.					
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 <u>March</u> , 19 <u>52</u> , to <u>May 5</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>53</u> , and that death occurred at <u>6:30 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Philip G. Kaul</u> (Degree or title) <u>MD MD.D</u>				23b. ADDRESS <u>411 Nichols Road</u>		23c. DATE SIGNED <u>May 6, 1953</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>May 7-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CARROLLTON</u>		24d. LOCATION (City, town, or county) (State) <u>Carrollton, Ky.</u>	
DATE REC'D BY LOCAL REG. <u>5-7-53</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Langford</u>		ADDRESS <u>Summit</u>	

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *W. B. Langford*

Licensed Embalmer No. *325*

P. O. Address *See Perm*

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

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