

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31985**
4673

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 15yrs		e. STREET ADDRESS (If rural, give location) 163 4611 Wabash Avenue 363 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4611 Wabash Avenue			

3. NAME OF DECEASED (Type or Print) a. (First) Lillian b. (Middle) Fern c. (Last) Rue			4. DATE OF DEATH (Month) (Day) (Year) Sept. 24 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 18, 1904	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator		10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel	11. BIRTHPLACE (City and State or Foreign Country) Mt. Vernon, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Otto Loerch	13b. MOTHER'S MAIDEN NAME NORA KNOWLES	14. NAME OF HUSBAND OR WIFE James F. Rue
---------------------------------------	---	---

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. 486-01-1486	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Osborne 4611 Wabash Avenue, K.C. Mo.
--	--	--

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 Days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Thrombosis		3 Days
	DUE TO (c) Metastatic Melanoma		3 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Malignant Mole on Rt. calf			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) 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 **7/14/53**, 19**53**, to **9/24/**, 19**53**, that I last saw the deceased alive on **9/23/**, 19**53**, and that death occurred at **9:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]	23b. ADDRESS 23-E-39th St. K.C. 2 Mo.	23c. DATE SIGNED 9/25/53
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE SEPT 28 1953	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
---	-------------------------------	--	---

DATE REC'D BY LOCAL REG. 9-28-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. H. Newcomer's Sons 1331 BRUSH CREEK KANSAS CITY, MO.
---	--	---

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.....
Signature of Student Embalmer

Signed *Robert J. Boyer*.....

Licensed Embalmer No. *4892*.....

P. O. Address *KC 10 MO*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.