No. 300
10.48

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# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 23251

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Registrar's No. 312

7000

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

**1. PLACE OF DEATH**
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Blue
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence, 506 S. Huttig

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐: no
e. STREET ADDRESS (If rural, give location): 506 S. Huttig

7000

**3. NAME OF DECEASED** (Type or Print)
a. (First): Lena
b. (Middle): A
c. (Last): Bigley

**4. DATE OF DEATH** (Month) (Day) (Year): Aug. 3, 1954

**5. SEX**: female
**6. COLOR OR RACE**: white
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): married
**8. DATE OF BIRTH**: Feb. 12, 1908
**9. AGE** (In years last birthday): 46 — 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): Clerk
**10b. KIND OF BUSINESS OR INDUSTRY**: stove mfg. co.
**11. BIRTHPLACE** (City and State or Foreign Country): Brock, Nebr.
**12. CITIZEN OF WHAT COUNTRY?**: USA

**13a. FATHER'S NAME**: John Douglas
**13b. MOTHER'S MAIDEN NAME**: Martha Wagner
**14. NAME OF HUSBAND OR WIFE**: Chas. W. Bigley

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no — (If yes, give war or dates of service): none
**16. SOCIAL SECURITY NO.**: 488 14 3532
**17. INFORMANT'S SIGNATURE OR NAME** — ADDRESS: Chas. W. Bigley, Kansas City, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Bronchiogenic Carcinoma, cerebral metabolism — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Bronchiogenic Carcinoma — 2 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**: Nov 19, 1953
**19b. MAJOR FINDINGS OF OPERATION**: Carcinoma of Right bronchus 162 X
**20. AUTOPSY?** YES ☐ 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* Feb 6, 1954, *to* Aug 3, 1954, *that I last saw the deceased alive on* Aug 3, 1954, *and that death occurred at* 6:20A *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): E H Horsch MD
**23b. ADDRESS**: 10912 1/2 Winner Rd Indy.
**23c. DATE SIGNED**: Aug 3, 1954

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 8/5/54
**24c. NAME OF CEMETERY OR CREMATORY**: Mt. Washington Cemetery
**24d. LOCATION** (City, town, or county) (State): Kansas City, Mo.

**DATE REC'D BY LOCAL REG.**: 8-5-54
**REGISTRAR'S SIGNATURE**: James [illegible] 354
**25. FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Geo C. Carson, Independence, Mo.

(Licensed Embalmer's Statement on Reverse Side)

AUG 27 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.