

FILED JUN 16 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18615**
2216

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 Ray	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	c. LENGTH OF STAY (in this place) 3 weeks	c. CITY OR TOWN Richmond	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: Research Hospital		e. STREET ADDRESS (If rural, give location) South Second	

3. NAME OF DECEASED (Type or Print) ELIZABETH DOLPHIN			4. DATE OF DEATH (Month) (Day) (Year) May 22, 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Sept. 7, 1887		9. AGE (In years last birthday) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and State or Foreign Country) Hamilton, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas Barris	13b. MOTHER'S MAIDEN NAME Isabel Young	14. NAME OF HUSBAND OR WIFE George Dolphin
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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 Mrs. Mary Nylund, Kansas City, Mo.	ADDRESS Kansas City, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suit. Arteriosclerotic Renal Artery		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) H.C.V.D.		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		443X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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 May 3, 1955, to May 22, 1955, that I last saw the deceased alive on May 22, 1955 and that death occurred at 9:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D.R. Black	23b. ADDRESS M.D. 924 Professional Bldg.	23c. DATE SIGNED 5/23/55
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE May 24, 1955	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Richmond, Missouri
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DATE REC'D BY LOCAL REG. 5-23-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Carter	ADDRESS Richmond, MO
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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 *Thomas J. Carter*.....

Licensed Embalmer No. *441*.....

P. O. Address... *Richmond*.....

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.