

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29926**
Registrar's No. **375**

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **5589**

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 Rural, Brookings		c. LENGTH OF STAY (in this place) 31 Yrs.	c. CITY OR TOWN Rural, Brookings
d. FULL NAME OF HOSPITAL OR INSTITUTION 8714 Thompson		e. STREET ADDRESS (If rural, give location) 8714 Thompson	

3. NAME OF DECEASED (Type or Print) Lillian Winfrey			4. DATE OF DEATH September 28 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 15 Jan 1889		9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (City and State or Foreign Country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Alvin Darling		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Gilbert A. Winfrey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MR. Gilbert A. Winfrey - 8714 Thompson	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma		INTERVAL BETWEEN ONSET AND DEATH 5 mo	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) C. A. of Colon		1 year	
		DUE TO (c) 153x			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma of sigmoid colon 4/5/55		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 **Feb 23, 1955**, to **9/28/55**, that I last saw the deceased alive on **9/27/55**, and that death occurred at **2125th**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS Independence, MO		23c. DATE SIGNED 9/28/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-1-55		24c. NAME OF CEMETERY OR CREMATORY Floral Hills	
				24d. LOCATION (City, town, or county) (State) Kansas City Missouri	

DATE REC'D BY LOCAL REG. 9-30-55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapels, Inc. K. C. Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

1-1-78

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 *Lloyd C. Marshall*

Licensed Embalmer No. *483*

P. O. Address *L. C. Marshall*

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.