FILED FEB 8 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 609

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4093 Registrar's No. 21

1. PLACE OF DEATH
a. COUNTY: Cass
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): East Lynne
c. LENGTH OF STAY (in this place): 20 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Cass
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): East Lynne
d. STREET ADDRESS (If rural, give location): 0190

3. NAME OF DECEASED (Type or Print)
a. (First): LUCY
b. (Middle):
c. (Last): TAYLOR

4. DATE OF DEATH (Month) (Day) (Year): Jan. 27-1956

5. SEX: F.
6. COLOR OR RACE: Wh.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct. 1-1871
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months 3, Days 26 — IF UNDER 24 HRS.: Hours, Min.

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): Lawrence Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: William Fish
13b. MOTHER'S MAIDEN NAME: Hester Smith
14. NAME OF HUSBAND OR WIFE: —

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 A. W. Deaver — ADDRESS: Harrisonville

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): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension & Cerebral Arteriosclerosis
DUE TO (c): 10 yrs

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: 331X
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* _____, 1948, *to* JAN 27, 1956, *that I last saw the deceased alive on* JAN 26, 1956, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O B Barger MD
23b. ADDRESS: Harrisonville Mo
23c. DATE SIGNED: 29 Jan 1956

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 29-56
24c. NAME OF CEMETERY OR CREMATORY: Clear Fork Cem.
24d. LOCATION (City, town, or county) (State): East Lynne Mo

DATE REC'D BY LOCAL REG.: Jan 30, 1956
REGISTRAR'S SIGNATURE: Dora Barnard 457-10
25. FUNERAL DIRECTOR'S SIGNATURE: A. D. Hartzler — ADDRESS: East Lynne

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
FEB 6 1956
HEALTH DEPARTMENT

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 A. D. Sandler

Licensed Embalmer No. 2717

P. O. Address East Lynne

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.