

Health, Welfare, Public Service, 300-56, Doctor, coroner, etc. must use only standard nomenclature in Part 18. No symptoms with no natural causes. Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STANDARD CERTIFICATE OF DEATH

FILED FEB 18 1957

4654
STATE FILE NUMBER
389

Registration District No. 149 Primary Registration District 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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		3548 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3116 Euclid		Length of stay in 1b 30 yrs		d. STREET (If outside, give location) ADDRESS 3116 Euclid	
3. NAME OF DECEASED (Type or print) First Middle Last ADA MAE CROFFORD			4. DATE OF DEATH Month Day Year Jan 25, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1898	9. AGE (In years last birthday) 58 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days 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 Home		11. BIRTHPLACE (City and state or country) Calloway Co., Mo.	
13. FATHER'S NAME W. B. Nichols			14. MOTHER'S MAIDEN NAME Lillie Copher		
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 Mrs. Dale Crofford Address 5748 Barrett Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive C.V. disease & failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic Bronchial Asthma</i> DUE TO (c) <i>Terminal Bronchial Pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs. 3 days.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>May 1954</i> to <i>1/24/57</i> and last saw her/him alive on <i>1/24/57</i> Death occurred at <i>1:55 PM 1/24/57 4:00 AM</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Fred H. Lundgren, Jr. M.D.</i>			22b. ADDRESS <i>315 Nichols Road</i>		22c. DATE SIGNED <i>1/25/57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <i>1-27-57</i>	23c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar 1800 E. Linwood		25. DATE RECD. BY LOCAL REG. <i>1-26-57</i>		26. REGISTRAR'S SIGNATURE <i>Neve Trindall</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Fred H. Lundgren, Jr.

MEDICAL CERTIFICATION

The First Lodge
Georgetown Bldg
Va 1-8833

1-4-30P

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James W. Wain*

Licensed Embalmer No. 46

P. O. Address *K.C., Va*

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