

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8580

FILED MAR 26 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1041

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 OR TOWN) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Goss Nursing Home			Length of stay in 445 yrs		d. STREET ADDRESS (If outside, give location) 4607 Olive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ELLA Middle M Last BUCHANAN				4. DATE OF DEATH Month March Day 4 Year 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 July 17 1878		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR 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) Iowa		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William E LaNier				14. MOTHER'S MAIDEN NAME Maude					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr Ilo V Buchanan 4607 Olive K C Mo.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis 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 years 4 years 4500	
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 9-12-57 to 3-4-57 and last saw her alive on 3-4-57 . Death occurred at 9 am in on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Frank Paul Laurezana M.D. (Degree or title) D				22b. ADDRESS 428 S. White Ave				22c. DATE SIGNED 3-4-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE March 6 1957		23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Kansas			
24. FUNERAL DIRECTOR John P Sheil Kansas City Missouri ADDRESS				25. DATE RECD. BY LOCAL REG. 3-6-57		26. REGISTRAR'S SIGNATURE Neva Minshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Frank Paul Laurezana

MEDICAL CERTIFICATION

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 *J. P. Sheil*

Licensed Embalmer No. 367

P. O. Address *K. C. M.*

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.