FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005363
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 465

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): General Hospital #1 — Length of stay in 1b: 30 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1004 Lydia — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Frank Middle: L. Last: Bickford

4. DATE OF DEATH: Month: 1 Day: 27 Year: 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 1-20-74

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Stone mason helper

11. BIRTHPLACE (City and state or country): Sabetha Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: —— Bickford

13b. MOTHER'S MAIDEN NAME: No record

14. NAME OF HUSBAND OR WIFE: Eola Bickford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Eola Bickford Address: 1004 Lydia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 4 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1-9-58, to 1-27-58 and last saw ~~he~~ alive on 1-27-58
Death occurred at 9:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. L. Burns, MD

22b. ADDRESS: General Hospital No. 1

22c. DATE SIGNED: 1-28-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan 30 1958

23c. NAME OF CEMETERY OR CREMATORY: Mt Washington

23d. LOCATION (City, town, or county) (State): Kansas City, Mo.

24. FUNERAL DIRECTOR ADDRESS: Mrs C.L.Forster Funeral Home Inc. Kas. City, Mo.

25. DATE RECD. BY LOCAL REG.: 1-29-58

26. REGISTRAR'S SIGNATURE: Vera Minshall

(Licensed Embalmer's Statement on Reverse Side)

B. I. Burns

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. Virgil Kennele

Licensed Embalmer No. 3599

P. O. Address K. C. Mo.

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.