

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025314

STATE FILE NUMBER

FILED AUG 15 1958

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3652

300
1-57

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|---|--|--|--|---|--|--|---|---|------------------------------------|---------------------------------------|-------|------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>—</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Mo.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Jackson Heights 31</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u> | | | Length of stay in lb <u>14 days</u> | | d. STREET ADDRESS (If outside, give location) <u>83-12 35 Ave</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LALE Lora C. Andrews</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 29, 1958</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 18, 1900</u> | | 9. AGE (In years last birthday) <u>57</u> | | FUNDER YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consulting Engineer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u> | | 11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>B. Bell Andrews</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Cora Clark</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Mary L. Andrews</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>097-01-8241</u> | | 17. INFORMANT Address <u>Jackson Hgts, New York</u> <u>Mary L. Andrews, 8312-35th Ave,</u> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | 4201 | | | | | |
| 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 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 <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 <u>July 15, 1958</u> to <u>July 29th</u> and last saw ^{her} him alive on <u>July 28, 1958</u> Death occurred at <u>12:15 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>M. Donald McFarland M.D.</u> | | | | | | 22b. ADDRESS <u>315 Nichols Rd. K.C. Mo</u> | | | 22c. DATE SIGNED <u>7-29-58</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | 23b. DATE <u>7-31-58</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Nemaha Cemetery</u> | | | 23d. LOCATION (City, town, or county) (State) <u>Nemaha, Nebraska.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar, 20 W. Linwood</u> | | | | ADDRESS <u>K. C. Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-30-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u> | | | | | |

All diseases in Part I must be causally related.

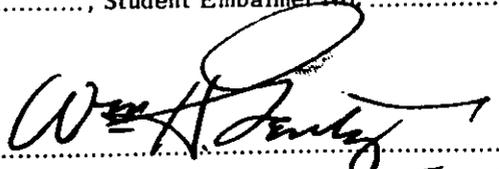
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
M. Donald McFarland



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 
Licensed Embalmer No. 5038
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.