

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017677

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2503 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Luke's Hospital</i>			Length of stay in 1b <i>40 yrs.</i>		d. STREET ADDRESS (If outside, give location) <i>5400 Myrtle</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lorraine Estella Denison</i>				4. DATE OF DEATH Month Day Year <i>May-19-1959</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec-18-1918</i>		9. AGE (In years less birthday) <i>40</i>	IF UNDER 1 YEAR Months Days <i>- -</i>	IF UNDER 24 HRS Hours Min. <i>- -</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (City and state or country) <i>K.C., Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13a. FATHER'S NAME <i>Gordon Kindall</i>			13b. MOTHER'S MAIDEN NAME <i>Gladys Venable</i>			14. NAME OF HUSBAND OR WIFE <i>Bernard Denison</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>500-03-9501</i>		17. INFORMANT Address <i>Mrs. Gladys Kindall Mo. K.C.</i>				
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>Acute Bronchopneumonia</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<i>491XH</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <i>Carcinoma of the Ovary with local extension</i>							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 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 <i>Kansas City</i>		COUNTY <i>Jackson</i>		STATE <i>Mo.</i>	
21. I attended the deceased from <i>10/6/53</i> to <i>5/19/59</i> and last saw her alive on <i>5/18/59</i> Death occurred at <i>5:15</i> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Richard L. Lehman, M.D.</i>				22b. ADDRESS <i>1103 Grand Kansas City 6, Mo.</i>			22c. DATE SIGNED <i>5/20/59</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>May 21-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Elmwood Cem.</i>			23d. LOCATION (City, town, or county) (State) <i>Kansas City, Mo.</i>			
24. FUNERAL DIRECTOR <i>C.H. Blackman & Son</i>				ADDRESS <i>200 N. K.C. Mo.</i>		25. DATE RECD. BY LOCAL REC. <i>5-20-59</i>		26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>	

Richard L. Lehman, M.D. only black ink or ribbon type if possible

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 *Bert B. Benne*

Licensed Embalmer No. *4656*

P. O. Address *S. C. Me*

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.