

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028931**

FILED VS SEP 4 1959

Registration-District No. 149 Primary Registration District No. 1002 Registrar's No. 4054 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>30 yrs</b>	c. CITY OR TOWN <b>Kansas city</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5621 South Benton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5621 South Benton</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Dane</b> Last <b>Aker</b>			4. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-83</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Berry Lawson</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>William S. Aker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>W.S. Aker, 5621 S. Benton, K.C. Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____	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.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>K.C.</b> COUNTY <b>Jackson</b> STATE <b>MO</b>
21. I attended the deceased from <b>April 1956</b> to <b>Aug 19, 1959</b> and last saw her alive on <b>Aug 18, 1959</b> Death occurred at <b>6:30 p.m.</b> of the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>H. E. K. George</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>Doctors Bldg. 63rd &amp; Holmes</b>	22c. DATE SIGNED <b>8-21-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belton Cemetery</b>	23d. LOCATION (City, town, or county) <b>Belton, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>H. E. K. George &amp; Sons Inc, Belton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-21-59</b>	26. REGISTRAR'S SIGNATURE <b>Deva Marshall</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Harold Raymond  
Decker Bldg.

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stirling E. Dodder

Licensed Embalmer No. 4911

P. O. Address Grandville

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.