WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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OCT 1 9 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

31938
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN Registration District No. 8
(b) Township Primary Registration District No. 100 Registered No. 987
(c) or City ST. JOSEPH. (d) Street No. ST. JOSEPH, HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 30 yrs. – mos. – ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME HARLEY-COOK-LESTER
(a) Residence, No. 2106 Washington St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE wht
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF Florence Lester

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 12 1865

7. AGE YEARS 74 MONTHS 2 DAYS 13 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Emp.
9. Industry or business in which work was done, as saw mill, bank, etc. of Wyeth Hdw. Co.
10. Date deceased last worked at this occupation (month and year) Apr. 1936
11. Total time (years) spent in this occupation yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER
13. NAME Marshall Lester
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Emma Waldron
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Lloyd A Lester Kansas City, Mo.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Ashland DATE 9-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roy Stamey St Joseph Mo

20. FILED Sept 26, 1939 H. J. Nestlebush
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-18, 1939, to 9-26, 1939
I last saw ~~him~~ alive on 9/25, 1939. Death is said to have occurred on the date stated above, at 4:00 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	9/18/39

Other contributory causes of importance:
Hypertension

Name of operation none Date of
What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury None, 19
Where did injury occur? none
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
none
Manner of injury none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) McGrimes, M. D.
(Address) 405 Kirkpatrick Bldg St Joseph Mo

(Licensed Embalmer's Statement on Reverse Side)

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 John H Hurley, Registered Apprentice No.....,
working under my personal supervision.

Signed John H Hurley

Licensed Embalmer No. 4050

P. O. Address 2335 S St Joseph

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 this body is not embalmed, above space should be left blank.