

N. E.—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.

Registration District No. 399

Primary Registration District No. 1002

JAN 13 1940

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Mo.
12 Years (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3435 Central
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Mrs. Lucy Lightner 525

8. (b) If veteran, name war No

8. (c) Social Security No. --

4. Sex F.

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Samuel C. Lightner

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Oct. 20th 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>2</u>	<u>3</u>	hr. _____ min.

9. Birthplace Laredo Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None
11. Industry or business At home

MOTHER FATHER

12. Name Greenberry Owens

13. Birthplace Unk. Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Susan Kilborn

15. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oscar L. Lightner
(b) Address 3435 Central

17. (a) Laredo, Missouri (b) Date thereof 12-25-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. Newcomer Sons

18. (a) Signature of funeral director 1401 Brush Creek Blvd.
(b) Address

19. (a) Dec 24, 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23rd
year 1939 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from Nov. 18th
1939 to Dec. 23rd, 1939;
that I last saw h. er alive on December 23rd, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Duration 93 C

Due to Senile arteriosclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? ! (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other)
Address Supt. K.C. Hosp. Date signed 12-25-39

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Emile M. Calhoun

Licensed Embalmer No. 3506

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