

## NOV 20 1940 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 197

Primary Registration District No. 5276

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Clay *Gallatin*  
 (b) City or town North Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Hi-way #10 North K.C. Mo.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
 (c) City or town Route #5  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. North Kansas City, Mo.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6  
 year 1940 hour 8 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
CORONER, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death skull fracture ✓ *Duration*  
internal injuries of chest

Due to automobile traumatism ✓

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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) accident

(b) Date of occurrence Oct 6, 1940

(c) Where did injury occur? North K. C. Missouri  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Junction Hi-ways #1 & #10  
 (Specify type of place) (e) Means of injury \_\_\_\_\_

While at work? \_\_\_\_\_

23. Signature Mrs. W. L. Young Coroner

Address Liberty Clay Co. Missouri

3. (a) PRINT FULL NAME George Milford Lester

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 496-05-8498

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased Feb. 20, 1921  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 7 16  
 hr. \_\_\_\_\_ min.

9. Birthplace Hamlin, Kansas  
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Ruberized Fabric Co.

12. Name Merle E. Lester

13. Birthplace Kansas City, Mo.  
 (City, town, or county) (State or foreign country)

14. Maiden name Marie Jones

15. Birthplace St Joseph, Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Merle E. Lester

(b) Address Rt #5 North K. C. Mo.

17. (a) Removal (b) Date thereof 10-8-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph, Mo.

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North Kansas City, Mo.

19. (a) 10-6-40 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

210M  
95

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-18-40

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.....

Harold L. Posson

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3605

P. O. Address North K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **35099**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **197**

Primary Registration District No. **5276**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Clay**  
(b) City or town **Ballwin**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME **Geo M. Lester**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **19** Months **7** Days **16** If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **6** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Spinal fracture of chest**  
Duration \_\_\_\_\_  
Interpretation of inquest \_\_\_\_\_

Due to **Automobile Traumatism**

Due to **Vital Power + Light pole fixed object injury**

Other conditions **occurred on # 10 State Highway**

Major findings: Of operations \_\_\_\_\_

Of autopsy **210 YW 27**

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 **W. L. Wyrong, Coroner** (M.D. or other)

Address **Liberty Mo** Date signed \_\_\_\_\_

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File **35099**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **197**

Primary Registration District No. **6276**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Clay**  
(b) City or town **Springfield**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Geo M. Hunter**

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **19** Months **9** Days **16** If less than one day hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Oct 7-40** (b) **John S. Hunter** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **6** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. **Wm W. Luyson** (M. D. or other) \_\_\_\_\_

Address **Liberty** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NO. 10055

SUPPLEMENTAL