

FILED JUN 18 1942

Registration District No. **299**

Primary Registration District No. **1002**

Registrar's No. **2229**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
LaSalle Hotel 922 Linwood Blvd. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether
In this community **1 Yr.**
years, months or days)

3. (a) PRINT FULL NAME **Mr. Henry LYSAGHT.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Nellie Lysaght** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **September 4th 1877**
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **2** If less than one day
hr. min.

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

10. Usual occupation **Accountant**

11. Industry or business **Mo. Public Service Comm.**

12. Name **John J. Lysaght**

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

14. Maiden name **Missouri Collins**

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

16. (a) Informant **Mrs. Nellie Lysaght.**

(b) Address **LaSalle Hotel 922 Linwood.**

17. (a) **Removal** (b) Date thereof **6/7/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Joseph Missouri.**

18. (a) Signature of funeral director **Melody-McGilley**
(b) Address **K. C. Mo.**

19. (a) **6-8-42** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **922 Linwood Blvd.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **2** hour **2:30** P.M.

21. I hereby certify that I attended the deceased from **Arrival** 19 **42**

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Primary thrombosis**

Due to **9/4**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **See above**

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) (c) Means of injury **6/6/42**

23. Signature **[Signature]** (M.D. or other) **6/6/42**
Address _____ Date signed _____

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

48
3
8

48
3
8

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

#2595

1363981

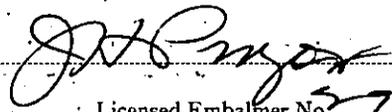
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No.....

3799

P. O. Address.....

K C

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, fact should be so stated above.