

FILED SEP 3 1942

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **Jackson**
 (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:
1110 Professional Bldg.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **XX**
(Specify whether years, months or days)
 In this community **About 2 days**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Kansas** (b) County **Sabette**
 (c) City or town **Parsons**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1419 Morgan Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **2**

3. (a) PRINT FULL NAME **Lester Martin Combs**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **511-09-3563**

4. Sex **Ma** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mrs. Carol Bird Combs** 6. (c) Age of husband or wife if alive **49** years
 7. Birth date of deceased **October 1 1887**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	10	16	hr. min.

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

10. Usual occupation **Newspaperman**

11. Industry or business **Parsons Daily Sun**

12. Name **Martin Sidney Combs**

13. Birthplace **No Record** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Davis**

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

16. (a) Informant **Mrs. Carol Bird Combs**

(b) Address **Parsons, Kansas**

17. (a) **Removal** (b) Date thereof **8-18-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Parsons, Kansas**

18. (a) Signature of funeral director **M. M. Crowe**
Kansas City, Mo.

(b) Address **8-17-42**
 19. (a) **8-17-42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **17**
 year **1942** hour **1:** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Anna**, 19____, 19____
 that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **acute stress acute pulmonary edema**
 Due to _____
 Due to _____

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

Major findings: Of operations _____
 Of autopsy **As for**

Duration _____
 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? _____
(Specify type of place)
 While at work _____ (Specify type of place) (e) Means of injury _____
 23. Signature **OTERH** (b) _____
 Address **Low 3** Date signed **8/17/42**

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

C

361

JUL 21 1957

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 A R Hainsefeld
Licensed Embalmer No. 4159
P. O. Address Kansas city 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, fact should be so stated above.