

No. 2
5-42
5-17-39
X32873

FILED APR 10 1944

Registration District No. 77

Primary Registration District No. 4134

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Clay Co. Mo.
 (b) City or town Smithville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 24 hrs. (Specify whether
 In this community 75 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
 (c) City or town Paradise
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME John Franklin Lizar
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 21 day year 44 hour 7.9 minute _____ M.
 21. I hereby certify that I attended the deceased from Jan 20 1944 to Jan 21 1944
 that I last saw him alive on Jan 20 1944 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 9
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May - 21 - 1868
 (Month) (Day) (Year)

Immediate cause of death Sepsis
Agglutination
 Due to Infection both hands &
one foot.
 Duration _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

8. AGE: Years 75 Months 8 Days _____ If less than one day _____ hr. _____ min.
 9. Birthplace Clay Co. Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business _____
 12. Name David Cruse Lizar
 13. Birthplace Clay Co. Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Emily Mc Adams
 15. Birthplace Clay Co. Missouri
 (City, town, or county) (State or foreign country)
 16. (a) Informant Ruben Peterson
 (b) Address Smithville Mo.
 17. (a) Burial (b) Date thereof Jan 22 - 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Paradise Cem
 18. (a) Signature of funeral director Rollins Mitchell
 (b) Address Platte City Mo.
 19. (a) Mar 24 - 1944 (b) Rich N Henay
 (Date received local registrar) (Registrar's signature)

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) Means of injury MS
 23. Signature EB Hobbs (M. D. or other) MS
 Address Smithville Mo Date signed 1-21-44

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-2-87

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.....

Rollins Mitchell Mortuary....., Registered Apprentice No.....
working under my personal supervision.

Signed Rollins Mitchell Mortuary
William G. Haskins
Licensed Embalmer No. 3947

P. O. Address Edgerton 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.

Registration District No. 72

Primary Registration District No. 4134

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Clay Smithville
 (b) City or town Smithville
(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 _____
years, months or days

3. (a) PRINT FULL NAME Johr. J. Lijan
 (b) If veteran, name war _____
 (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 21
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days _____
Unless than one day min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
 Year 1964 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____
 that I last saw him _____ alive on _____
 and that death occurred on the date and hour stated above _____
 immediate cause of death _____

Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 9 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) _____
 (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 _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

APR 11 1964

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

MOTHER FATHER

RECORD SHOW LEFT HAND FINGER CUT BY HIGH SPEED ROTARY CUTTER IN MILL TO HOSPITAL REFERRED TO POLY. ENTIRE HANDED WITH 29. POLY. 24A

10717