

FILED OCT 23 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4152

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:
Little Sisters of the Poor 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Months
In this community 11 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No 5331 Highland 8
(If rural, give location)
(e) Citizen of foreign country? 0
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CAROLINE LYMAN

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

4. Sex Female 5. Color or race White 6. (a) Single, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 1 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Fred Lyman
13. Birthplace No record
(City, town, or county) (State or foreign country)
14. Maiden name Barbara Miller
15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Sister & Thiele
(b) Address 5331 Highland

17. (a) Removal Emporia, Kansas
(Burial, cremation, or removal) (b) Date thereof 10/9/45
(Month) (Day) (Year)

(c) Place: burial or cremation Emporia, Kansas

18. (a) Signature of funeral director Walter E. ...
(b) Address 20 West Linwood

19. (a) 10-9-45 (b) A Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5th day Oct
year 1945 hour 10:30 minute P M.

21. I hereby certify that I attended the deceased from June 28th
1945 to Oct 5 1945
that I last saw her alive on Oct 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 5 Days
Due to Chronic Myocarditis 11 year

Due to Arterio Sclerosis 15 year

Other conditions (Include pregnancy within 3 months of death) 93 d

Major findings: Of operations _____
Of autopsy No 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 0

23. Signature John T. Shinner (M. D. or other) M.D.
Address 402 Bryant Bldg Date signed 9/9/45

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

18
3
8

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 Maudie Adair

Licensed Embalmer No. 4016

P. O. Address Honour City, Miss

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.