

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1550**
Registrar's No. **5363**

FILED JAN 21 1946
Registration District No. **199**

Primary Registration District No. **1002**

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

100333

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: 6908 Bellfontaine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 42 yrs (Specify whether
In this community _____
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. 6908 Bellfontaine 8
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elmer E. Lobdell

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

4. Sex Male 5. Color or race w 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Dec-6-1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Lobdell

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

14. Maiden name No Record

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant George E. Lobdell

(b) Address 7115 Bellfontaine

17. (a) Buried (b) Date thereof Dec 27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvinian

18. (a) Signature of funeral director Mrs C.R. Font

(b) Address 918 Franklin

19. (a) 12-27-45 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1945 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12-23
1945 to 12-24 1945
that I last saw him alive on 12-24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Rupture of Aortic Aneurysm non-syphilitic
Due to Arteriosclerosis

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 96

Major findings: _____
Of operations _____
Of autopsy Rupture of Aortic Aneurysm

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C.P. Richter D.D. (M.D. or other) _____
Address 7204 Prospect Date signed 12-25-45

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..... *Joe B. Yoder*

Licensed Embalmer No..... *4173*

P. O. Address..... *K. C. 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.