

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

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 hrs.  
(Specify whether  
 In this community 30 yrs  
years, months or days)

3. (a) PRINT FULL NAME William Lightner  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife no record  
 6. (c) Age of husband or wife if alive no record years  
 7. Birth date of deceased Aug - 25 1876  
(Month) (Day) (Year)

8. AGE: Years 70 Months 58 Days 6  
 If less than one day no hr. no min.

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

10. Usual occupation Rubber Truck driver

11. Industry or business Lightner

12. Name Lightner

13. Birthplace no record  
(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 Ms. Georgia Livingston

(b) Address 701 W. 16th

17. (a) Burial (b) Date thereof May 5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Miss C.P. Foster

(b) Address 918 Broadway

19. (a) 5-3-47 (b) Geraldine Holmes  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 48  
Kansas City  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 701 W. 16  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 1  
 year 1947 hour 12 minute 20 A. M.

21. I hereby certify that I attended the deceased from April 30 1947 to May 1 1947;  
 that I last saw him alive on May 1 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 94a  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy See above  
 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) (e) Means of injury

23. Signature Wm W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 5-1-47

*Dr. Lambert*

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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..... *Dean Owens* .....

Licensed Embalmer No. *4280* .....

P. O. Address..... *918 Brooklyn  
R. C., Md.* .....

**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.**