

Registration District No. **147** Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson B.**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 hours** (Specify whether years, months or days)

In this community **5 years**

3. (a) PRINT FULL NAME **William B. Lochmiller**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **513-10-9786**

4. Sex **male** **5. Color or race** **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Irene Lochmiller**

6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **March 14 1911**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
36	1	11	XX XX min.

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

10. Usual occupation **Office Manager**

11. Industry or business **Lock Joint Pipe Co.**

MOTHER FATHER

12. Name **Cary Lochmiller**

13. Birthplace **Independence Kansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Carlian Boylies**

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

16. (a) Informant **Mrs Carlian Lochmiller**

(b) Address **Independence Kansas**

17. (a) Removal **(b) Date thereof April 25-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Independence Kansas**

18. (a) Signature of funeral director **Morton-Smith's F.H.**

(b) Address **North Kansas City**

19. (a) 4-26-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clay**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **R.R. 10 Green Haven Annex N.K.C.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **XXXX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **25**
year **1947** hour **12** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **Pathologist** 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 Cardiac Failure**

Due to **Arteriosclerosis**

Due to **Hypertensive Heart Disease**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Arteriosclerosis of heart**

Of operations _____

Of autopsy **about**

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?) _____ (e) Means of injury _____

23. Signature **Russell J. ...** (M. D. or other)

Address **St. Joseph Hospital** Date signed **26 Apr 47**

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

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.....

Chester L. Fleming....., Registered Apprentice No. *447*
working under my personal supervision.

Signed *Theron O Smith*.....

Licensed Embalmer No. *3928*.....

P. O. Address *North Kansas City*.....

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.