

S. No. 2  
DOM-5-43  
ev. 5-17-39  
I X36671

FILED JUN 23 1947

State File No. \_\_\_\_\_

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 2532

1. PLACE OF DEATH

(a) County Jackson

(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community 6 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson <sup>48</sup>

(c) City or town K.C. <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 1600 Topping <sup>80</sup>  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN LOUIS LITYMAN JR.

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 8  
year 1947 hour 1<sup>20</sup> minute a M.

21. I hereby certify that I attended the deceased from born, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race white 6. (a) Single, widowed, 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 May 2 1947  
(Month) (Day) (Year)

Immediate cause of death Pneumonia <sup>Duration</sup>

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

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

Other conditions 107  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

1 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace K.C. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation infant

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Jno. Lityman

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

14. Maiden name Lorene Patter

15. Birthplace Springfield Mo  
(City, town, or county) (State or foreign country)

Major findings: 107

Of operations \_\_\_\_\_

Of autopsy yes as above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Jno. Lityman

(b) Address 1600 Topping

17. (a) Burial (b) Date thereof 6/10/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys

18. (a) Signature of funeral director Schubert

(b) Address City

19. (a) 6-10-47 (b) Geraldine Holmes  
(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)

(e) Means of injury 2

23. Signature Jane Walker (M. D. or other) Pain

Address 1424 1/2 St. Pkwy Date signed 6-9-47

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

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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..... *Gary Buffington* .....

Licensed Embalmer No. *2756* .....

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. "**