

FILED JUN 25 1949

STANDARD CERTIFICATE OF DEATH

State File No. **19654**
2635

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City <u>17</u>		c. LENGTH OF STAY (In this place) 8 DAs.	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Odessa		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke Hospt.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) a. (First) Dora b. (Middle) S. c. (Last) Lightner			4. DATE OF DEATH (Month) (Day) (Year) June 17, 1949
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH Feb. 8, 1860
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kentucky /
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Joseph Sands SAMS	
13b. MOTHER'S MAIDEN NAME Mary Lookhart		14. NAME OF HUSBAND OR WIFE J.W. Lightner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lee Roberts Kansas City, Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis, left INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:00 P. m., from the causes and on the date stated above.			
23a. SIGNATURE E. G. H. Schmidt		23b. ADDRESS St. Ambrose Hospital	
23c. DATE SIGNED 17 June 1949			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 20, 1949	
24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Mausoleum		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 6-18-49		REGISTRAR'S SIGNATURE Seraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE Husman-Sparks		ADDRESS Odessa, Mo.	

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed William T. Sparks

Signed.....
Student Embalmer

Licensed Embalmer No. # HV431

P. O. Address Odessa, 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.