

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30406  
3646

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1052 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>5 years</b>		d. STREET ADDRESS (If rural, give location) <b>3231 Montgall</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>MARTIN</b> b. (Middle) <b>L.</b> c. (Last) <b>LYNE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>August 24 1949</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>April 4, 1889</b>		9. AGE (In years last birthday) <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Camden, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Martin Lyne</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Hopkins</b>		14. NAME OF HUSBAND OR WIFE <b>Myrtle Lyne</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Myrtle L. Lyne</b> ADDRESS <b>3231 Montgall K.C. Mo</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Tuberculous Meningitis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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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 **7:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Russell W. Kerr</b> (Degree or title)		23b. ADDRESS <b>St. Joseph Hospital</b>		23c. DATE SIGNED <b>24 Aug 49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Aug. 25, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lena Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>Lena Illinois</b>					

DATE REC'D BY LOCAL REG. <b>8-24-49</b>		REGISTRAR'S SIGNATURE <b>Heraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>WILKS FUNERAL HOME</b> ADDRESS <b>2315 Linwood K.C.3 Mo</b>	
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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Chas E Wilks* .....

Licensed Embalmer No. *9644* .....

P. O. Address *9315 Linwood* .....

**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.