

FILED MAR 3 1951
 STANDARD CERTIFICATE OF DEATH

State File No. 4822
 Registrar's No. 586

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hosp		d. STREET ADDRESS (If rural, give location) 3524 Flora Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Homer b. (Middle) A. Lightfoot c. (Last) Lightfoot		4. DATE OF DEATH (Month) (Day) (Year) Feb. 6th, 51	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 27th 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY Oil Company	9. AGE (In years last birthday) 69
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Thomas J. Lightfoot		13b. MOTHER'S MAIDEN NAME Sarah E. Riffe	14. NAME OF HUSBAND OR WIFE Ada Lightfoot
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no None		16. SOCIAL SECURITY NO. 493-22-5496	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Richard Lightfoot 409 So. Lawn
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral and pontine hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertensive heart disease DUE TO (c) chronic glomerular nephritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1 yr before recurrence INTERVAL BETWEEN ONSET AND DEATH 6 hrs 3+ yrs 7 592*	
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) m.	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 on St. Mary's Hosp. 1951, that I last saw the deceased alive on 6 hrs., 1951, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE James H. O'Neil, (Degree or title) Chief of Staff St. Mary's Hosp.		23b. ADDRESS 424 Professional Bldg.	23c. DATE SIGNED 2-7-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/9/51	24c. NAME OF CEMETERY OR CREMATORY Floral Hills Cem.	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 2-8-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Earp & Sons K.C. Missouri	

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

Dr. O'Neal

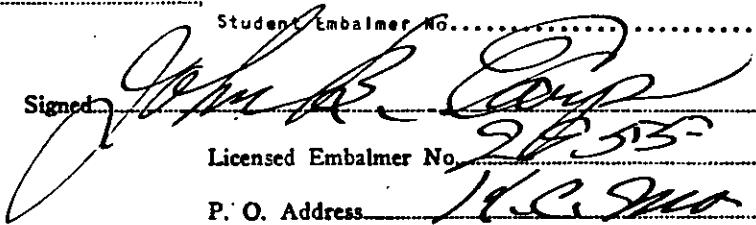
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed  _____

Signed.....
Student Embalmer

Licensed Embalmer No. 2855

P. O. Address 1429th

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.