

FILED SEP 27 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31717

State File No.

4073

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 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	
c. LENGTH OF STAY (In this place) 42 yrs		d. STREET ADDRESS (If rural, give location) 607 Woodland	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		317	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle)	c. (Last) Layman	4. DATE OF DEATH (Month) (Day) (Year) 9 13 52
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-1-1872	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Meter reader	10b. KIND OF BUSINESS OR INDUSTRY Kansas City P. & Light Co.	11. BIRTHPLACE (City and State or Foreign Country) Newton, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William H. Layman	13b. MOTHER'S MAIDEN NAME Henkel	14. NAME OF HUSBAND OR WIFE Elizabeth Layman
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Elizabeth Layman	ADDRESS 607 Woodland
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia		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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Sept. 10, 1952, to Sept. 13, 1952, that I last saw the deceased alive on Sept. 13, 1952, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE B. I. Burns (Degree or title) M.D.	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 9-15-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-15-1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 9-15-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. C. L. Forster	ADDRESS Kansas City, Missouri
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Hi Dante

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 _____

Joe B. Yoder

Licensed Embalmer No. *4173*

P. O. Address *P.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.