

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35040

State File No.

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4459 Registrar's No. 49

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

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Osceola</u>		c. LENGTH OF STAY (in this place) <u>7 days</u>	c. CITY OR TOWN <u>Osceola</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Todd's Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <u>6930</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Fred</u>	b. (Middle) <u>A.</u>	c. (Last) <u>Lytton</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct; 2, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec; 2, 1880</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Clair County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>David K. Lytton</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Dollie Lytton</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bill Lytton, Kansas City Mo;</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory failure</u>		<u>2 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Hypertension</u>		<u>1 week</u> <u>unknown</u>
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 type="checkbox"/> NO <input checked="" 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) <u>331 X</u>
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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? _____
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22. I hereby certify that I attended the deceased from 9-26, 1954, to 10-2, 1954, that I last saw the deceased alive on 10-2-54, 1954, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>[Signature]</u>	23b. ADDRESS <u>Box 127 - Osceola Mo</u>	23c. DATE SIGNED <u>10-8-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-5-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>	24d. LOCATION (City, town, or county) (State) <u>Osceola Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-8-54</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F.B. Goodrich - Osceola Mo</u>
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Paul J. Stone*.....

Licensed Embalmer No. *399*.....

P. O. Address *Orwell*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.