

BIRTH NO. _____		REG. DIST. NO. 274		PRIMARY REG. DIST. NO. 3052		Registrar's No. 87	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)			
a. COUNTY Pettis		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		a. STATE Kansas		b. COUNTY ? 815	
c. LENGTH OF STAY (in this place) 10 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbus		d. STREET ADDRESS (If rural, give location) 214 W. Mulberry			
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Hospital				d. STREET ADDRESS (If rural, give location) 214 W. Mulberry			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) Nellie		b. (Middle) E.		c. (Last) LYERLA		4. DATE OF DEATH (Month) (Day) (Year) March 31 1955	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH March 21 1879		9. AGE (In years last birthday) 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Carl Junction Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Lane Williams		13b. MOTHER'S MAIDEN NAME Clarinda Nash		14. NAME OF HUSBAND OR WIFE Fournier C. Lyerla			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ralph Cross		ADDRESS Sedalia	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia.				Interval between ONSET AND DEATH 24 hours.			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				II. OTHER SIGNIFICANT CONDITIONS			
ANTECEDENT CAUSES				DUE TO (b) Cardio Vascular Disease Over 5 yrs			
Asorbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) Diabetes Over ten years.			
Arterio Sclerosis- Advanced						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Medical treatment only.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None.		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) None.		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 Over ten days, to March 31st 55, that I last saw the deceased alive on March 31st, 1955, and that death occurred at 9:55 Pm., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Jno. B. Carlisle, M.D.				23b. ADDRESS Mrs. B. Carlisle, Sedalia, Missouri.		23c. DATE SIGNED 4-1-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-1-55		24c. NAME OF CEMETERY OR CREMATORY Park cemetery		24d. LOCATION (City, town, or county) (State) Columbus Kansas	
DATE REC'D BY LOCAL REG. 4/1/55		REGISTRAR'S SIGNATURE Lavinia Coonts Deputy		25. FUNERAL DIRECTOR'S SIGNATURE 251-7 McLaughlin Bros		ADDRESS Sedalia	

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 _____

Licensed Embalmer No. 31530

P. O. Address Sodalia 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.