

FILED MAR 14 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4776

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 830

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (in this place) <u>17 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>		e. STREET ADDRESS (If rural, give location) <u>10 347 Maple 31<sup>st</sup></u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Lizzie</u>	b. (Middle) <u>LILLIAN</u>	c. (Last) <u>Forte</u>	(Month) <u>2</u>	(Day) <u>23</u>	(Year) <u>1956</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-31-1880</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Wheeling, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John B. Lyons</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Eliah</u>	14. NAME OF HUSBAND OR WIFE <u>John Forte</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>_____</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lillian Shockley</u>		ADDRESS <u>347 Maple</u>
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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			INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u>			
	ANTECEDENT CAUSES			
	Morbidity 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.			<u>4201</u>

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)	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 Feb. 22, 1956, to Feb. 23, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 1:25A m., from the causes and on the date stated above.

23a. SIGNATURE <u>B.I. Burns</u> (Degree or title)	23b. ADDRESS <u>24th &amp; Cherry</u>	23c. DATE SIGNED <u>2-24-1956</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-25-1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Wheeling, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>2-24-56</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C.H. Blackman Son Inc.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

K.C., Mo.

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.....  
Signature of Student Embalmer

Signed *Bert B. Benne*.....

Licensed Embalmer No. *465*

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