

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41583
STATE FILE NUMBER
5370

FILED DEC 31 1956

Registration District No. 149 Primary Registration District 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, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		d. STREET ADDRESS (If outside, give location) 520 Admiral	

3. NAME OF DECEASED (Type or print) First Leroy Middle L. Last Lester			4. DATE OF DEATH Month 12 Day 8 Year 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1900	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (City and state or country) Salina, Kansas	
13. FATHER'S NAME George Lester			14. MOTHER'S MAIDEN NAME Viola Harless		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-01-0400		17. INFORMANT Address Mrs. Grace Lester, 520 Admiral	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of splenic artery		INTERVAL BETWEEN ONSET AND DEATH 151 X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) post operative DUE TO (c) carcinoma of stomach		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 10 Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **Dec. 8, 1956** to **Dec. 8, 1956** and last saw ~~him~~ ^{her} alive on **Dec. 8, 1956**
Death occurred at **10:05 p.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. I. Burns, M.D.	22b. ADDRESS 24th & Cherry	22c. DATE SIGNED 12-10-56
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23a. BURIAL, CREMATION, REMOVAL (State city)	23b. DATE Dec 11, 1956	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR ADDRESS D.W. Newcomers Lane Kansas City, Mo		25. DATE RECD. BY LOCAL REG. 12-11-56	26. REGISTRAR'S SIGNATURE Reva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

MEDICAL CERTIFICATION

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 *Raymond M. Hardy*.....

Licensed Embalmer No. *49*.....

P. O. Address *Indigo*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
- 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.