

FILED JUL 5 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 708

300
1-56

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hospital</u>		Length of stay in 1b <u>2 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>724 N. 10th Street</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lyle</u> Middle <u>L.</u> Last <u>Lathrop</u>			4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1892</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sammy's Drug Store</u>	11. BIRTHPLACE (City and state or country) <u>Ravanna, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Henry Lathrop</u>		13b. MOTHER'S MAIDEN NAME <u>Effie Holmes</u>		14. NAME OF HUSBAND OR WIFE <u>Carolyn Lathrop</u>	
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. <u>499-36-7104</u>	17. INFORMANT Address <u>Mrs. Carolyn Lathrop St. Joseph, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portal cirrhosis & hepatic failure (Failure)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6-25-57</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>					?
DUE TO (c) <u>Common Duod obstruction & stone approx</u>					<u>5-9-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>584X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>5-10-56</u> to <u>6-30-57</u> and last saw ^{him} alive on <u>6-29-57</u> Death occurred at <u>5 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wm. B. Reath</u> (Degree or title)			22b. ADDRESS <u>316 N. 10th St Joseph, Mo.</u>		22c. DATE SIGNED <u>6-30-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>June 30, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Princeton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Princeton, Missouri.</u>	
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</u>			25. DATE RECD: BY LOCAL REG. <u>July 2, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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JUL 10 1957

FEB 19 1958

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 *Lin J. Chan*

Licensed Embalmer No. *4579*

P. O. Address *St. Joseph*

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.