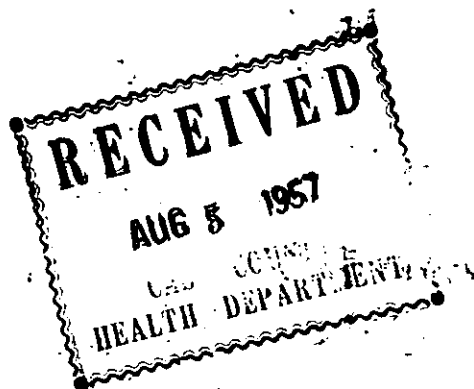


FILED AUG 6 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **23847**

BIRTH NO. _____		REG. DIST. NO. 57		PRIMARY REG. DIST. NO. 4092		Registrar's No. 106	
1. PLACE OF DEATH a. COUNTY Cass				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cass			
b. CITY (If outside corporate limits, write RURAL and give township) Harrisonville		c. LENGTH OF STAY (in this place) 5 mo		c. CITY OR TOWN Harrisonville		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF DECEASED Memorial Hospital				e. STREET ADDRESS (If rural, give location) 800 Butler Drive			
3. NAME OF DECEASED a. (First) WILL b. (Middle) LIPHUS c. (Last) AMENT				4. DATE OF DEATH (Month) (Day) (Year) July 25 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb 2 1878	
9. AGE (in years, months, days) 79		10. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Mail Messenger Retired		11. KIND OF BUSINESS OR INDUSTRY Cass Co Mo. USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Bud Ament		14. MOTHER'S MAIDEN NAME Olivia F. Shingleton		15. NAME OF HUSBAND OR WIFE Daisy Ament			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 888-36-7067		18. INFORMANT'S SIGNATURE OR NAME DAISY AMENT Harrisonville Mo			
19. 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Chronic Nephrosclerosis			
19a. DATE OF OPERATION ✓		19b. MAJOR FINDINGS OF OPERATION ✓		20. AUTOPSY? 2 YES ☐ NO ☒		21. HOW DID INJURY OCCUR? 331x	
21a. ACCIDENT, SUICIDE, HOMICIDE ✓		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ✓		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 331x			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. ✓		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? ✓			
22. I hereby certify that I attended the deceased from 1853 to 1942 , 1957, that I last saw the deceased alive on 11 17 m., 1957, and that death occurred at 11 17 m., from the causes and on the date stated above.							
23a. SIGNATURE W. J. Barger MD				23b. ADDRESS Harrisonville Mo		23c. DATE SIGNED 27 July 1957	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 28-1957		24c. NAME OF CEMETERY OR CREMATORY Burford Cemetery		24d. LOCATION (City, town, or county) (State) Harrisonville Mo	
DATE REC'D BY LOCAL REG. July 28 1957		REGISTRAR'S SIGNATURE Alora Barnard		FEDERAL DIRECTOR'S SIGNATURE Wm. H. Barger		ADDRESS Harrisonville Mo	



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 James R. Phillips
Licensed Embalmer No. 464

P. O. Address Harrison

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.