

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39298

STATE FILE NUMBER

Health,  
& Welfare  
S. Public  
Health Service

S. 300  
v. 1-56

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1282

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> <u>01170</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp.</u>		Length of stay in lb <u>45 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>1110 Highly St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Daniel</u> Last <u>Lysaght</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</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>Aug. 20, 1906</u>	9. AGE (In years last birthday) <u>51</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>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Light &amp; Power Co.</u>		11. BIRTHPLACE (City and state or country) <u>Leavenworth, Kans.</u>	
13. FATHER'S NAME <u>Leo Lysaght</u>			14. MOTHER'S MAIDEN NAME <u>Helen Todd</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-10-6630</u>		17. INFORMANT <u>Fay Lysaght</u> Address <u>1110 Highly City</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>Drowning</u>		INTERVAL BETWEEN ONSET AND DEATH <u>none</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input checked="" 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.) <u>Slipped while walking on wet concrete fell into intake well</u>	
20c. TIME OF INJURY Hour <u>2</u> Month <u>Nov</u> Day <u>25</u> Year <u>1957</u> p. m. <u>00</u>		
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Light + Power Co</u>	20f. CITY, TOWN, OR LOCATION <u>St. Joseph Buchanan MO</u>
21. I attended the deceased from <u>viewed body</u> and last saw him <u>Nov 22 57</u> Death occurred at <u>2 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Samuel M. Buchanan</u> (Degree or title) Coroner		22b. ADDRESS <u>214 N. Kirkpatrick Bldg St. Joseph 8, Mo</u>
22c. DATE SIGNED <u>Nov 23 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-25-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Herman W. Sidenfader</u>	ADDRESS <u>St. Joseph Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 25, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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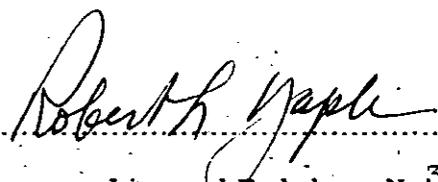
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STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 3308

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.