

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040061  
STATE FILE NUMBER

FILED NOV 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5313

300  
1-57

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</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>Research</u> Length of stay in lb <u>25 Years</u>		d. STREET ADDRESS <u>4012 Locust</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle _____ Last <u>Lydic</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APPROX.</u>		
9. AGE (In years last birthday) <u>80 YRS</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Jack Kiehl</u>			
13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE <u>John Lydic Deceased</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. _____			
17. INFORMANT <u>Edna M. Lydic</u> Address <u>R.F.D.#2 Lawrence</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>Peritonitis - Probably from leaking appendix</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Ceblain of the brain - metastases</u> DUE TO (c) <u>Cardiac Decompenation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 + days</u> <u>3 + months</u> <u>6 + months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ 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>Aug 3 1958</u> to <u>Nov 10 '58</u> and last saw her alive on <u>Nov. 9 1958</u> Death occurred at <u>12:35</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank B. Leitz M.D.</u>		22b. ADDRESS <u>1530 Poynter St. Kansas City Mo.</u>			
22c. DATE SIGNED <u>11-11-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE <u>Nov. 12 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>			
23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		24. FUNERAL DIRECTOR <u>J.P. Louis</u> ADDRESS <u>First Home K.C. Mo.</u>			
25. DATE RECD. BY LOCAL REG. <u>11-11-58</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Frank B. Leitz



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 *Guy Buffington* .....

Licensed Embalmer No. *2756* .....

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.