

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021499

STATE FILE NUMBER

FILED JUL 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3173

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Jackson Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>A Hospital</b>		Length of stay in lb. <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>1023 Calvin</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>G.</b> Last <b>Lockard</b>			4. DATE OF DEATH Month <b>6th</b> Day <b>25th</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-96</b>	9. AGE (In years last birthday) <b>63 yrs</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS: _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Security</b>	11. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		

13a. FATHER'S NAME <b>Hugh Lockard</b>		13b. MOTHER'S MAIDEN NAME <b>Nannie Graves</b>		14. NAME OF HUSBAND OR WIFE <b>Orabelle Lockard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 9-20-17 to 11-10-18</b>		16. SOCIAL SECURITY NO. <b>496095970</b>	17. INFORMANT <b>V. A. Hospital Records, K.C., Mo.</b> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cardiac failure</b>  DUE TO (c) <b>Pulmonary emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH
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.) <b>5271</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Mo</b>	COUNTY <b>Jackson</b>	STATE <b>Mo</b>
21. // attended the deceased from <b>June 24, 1959</b> to <b>June 25, 1959</b> Death occurred at <b>4:35 p</b> m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Andrew J. Randolph, M.D.</b>	22b. ADDRESS <b>Va. Hospital, Kansas City, Mo</b>	22c. DATE SIGNED <b>6-25-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
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24. FUNERAL DIRECTOR <b>Gibson &amp; Son Funeral Home</b>	ADDRESS <b>K.C.K.</b>	25. DATE RECD. BY LOCAL REG. <b>6-29-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Paul E. Libon*

Licensed Embalmer No. 3135  
P. O. Address *Bayville*

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.