

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025273

STATE FILE NUMBER  
32227

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 32227

S. 300  
v. 1-57

|                                                                                                                                                                                                                                            |                                  |                                                                                                                                                             |                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>                                                                                                                                                                                              |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |                                                                                                                                                              |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>                                                                                                                                                    |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        | c. CITY OR TOWN <b>Kansas City</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>3929 Walnut</b>                                                                                                                                          |                                  | Length of stay in lb<br><b>39 yrs</b>                                                                                                                       | d. STREET ADDRESS (If outside, give location)<br><b>3929 Walnut</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Laura Belle Lyman</b>                                                                                                                                                       |                                  |                                                                                                                                                             | 4. DATE OF DEATH<br>Month Day Year<br><b>July 1 1959</b>                                                                                                     |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 10, 1870</b>                                                                                                                     |
| 9. AGE (In years last birthday)<br><b>89</b>                                                                                                                                                                                               |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                                                                                                   | IF UNDER 24 HRS<br>Hours Min.                                                                                                                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                                                            | 11. BIRTHPLACE (City and state or country)<br><b>Chicago Illinois</b>                                                                                        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                              |                                  | 13a. FATHER'S NAME<br><b>William S. Cash</b>                                                                                                                |                                                                                                                                                              |
| 13b. MOTHER'S MAIDEN NAME<br><b>Mary Craney</b>                                                                                                                                                                                            |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>William R. Lyman</b>                                                                                                      |                                                                                                                                                              |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wt or dates of service)<br><b>No None</b>                                                                                                                 |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>                                                                                                                      |                                                                                                                                                              |
| 17. INFORMANT<br><b>Leonard A Lyman (son) St Joseph</b>                                                                                                                                                                                    |                                  | Address                                                                                                                                                     |                                                                                                                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b>                                                                                 |                                  |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b>                                                                                                            |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                                                                                                         |                                  |                                                                                                                                                             |                                                                                                                                                              |
| 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?<br>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<br>Hour a.m. Month, Day, Year p.m.                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                                                                                                                                              |
| 20d. INJURY OCCURRED WHILE AT <input 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                                                                                                                                                                                                               |                                  | COUNTY                                                                                                                                                      | STATE                                                                                                                                                        |
| 21. I attended the deceased from <b>12-17-58</b> to <b>6-30-59</b> and last saw her/him alive on <b>6-30-59</b><br>Death occurred at <b>12.25a.24</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |                                                                                                                                                             |                                                                                                                                                              |
| 22a. SIGNATURE (Degree or title)<br><b>R M Lilliey D.O.</b>                                                                                                                                                                                |                                  | 22b. ADDRESS<br><b>3915 Main St.</b>                                                                                                                        | 22c. DATE SIGNED<br><b>7-1-59</b>                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                 | 23b. DATE<br><b>July 3, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>                                                                                                  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph Missouri</b>                                                                                  |
| 24. FUNERAL DIRECTOR<br><b>Muehlebach Kan City, Mo</b>                                                                                                                                                                                     |                                  | ADDRESS<br><b>6800 Troost</b>                                                                                                                               | 25. DATE RECD. BY LOCAL REG.<br><b>7-1-59</b>                                                                                                                |
| 26. REGISTRAR'S SIGNATURE<br><b>neva minshall</b>                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                                                                                                                                              |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

R. M. Lilliey

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.

weirby B.D.  
we 1-2715  
7,11 12:30

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 *J. S. Crowell* .....

Licensed Embalmer No. *4904* .....

P. O. Address *H. C. Me* .....

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.