

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032731

FILED VS SEP 28 1959/50

Registration District No. _____ Primary Registration District No. 5577 Registrar's No. 206

STATE FILE NUMBER

IDED

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|--|--|---|--|---|--|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie | | Length of stay in lb 18 days | | c. CITY OR TOWN Independence | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hosp. | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2123 Norwood | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle _____ Last Lyle | | | | 4. DATE OF DEATH Month September Day 21 Year 1959 | | | | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/17/1886 | | 9. AGE (last birthday) 72 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and state or country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME W. D. Lyle | | | | 13b. MOTHER'S MAIDEN NAME Nannie Shimmessel | | | | 14. NAME OF HUSBAND OR WIFE Maud Lyle de | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 499-07-7123 | | 17. INFORMANT Mrs. Stanley Perkins Address Indep | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | 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) | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? 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 Hour _____ a.m. _____ p.m. | | Month, Day, Year | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 9-3-59 to 9-21-59 and last saw her/him alive on 9-21-59 Death occurred at 4:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE Philip Jager M.D. (Degree or title) | | | | 22b. ADDRESS Lee's Summit, Mo | | | | 22c. DATE SIGNED 9/21/59 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Sept 23, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Grain Valley | | 23d. LOCATION (City, town, or county) (State) Grain Valley, Mo | | | | | | | |
| 24. FUNERAL DIRECTOR OTT & MITCHELL ADDRESS INDEP. MO. | | | | 25. DATE RECD. BY LOCAL REG. 9-22-59 | | 26. REGISTRAR'S SIGNATURE M. Blangford | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.