

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-042110**

**FILED VS. DEC 12 1960**

**5854**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5854

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Buchanan</u> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson City</u>            |  | Length of stay in lb <u>6 Weeks</u>  | c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp.</u> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <u>2218 Puller</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <u>UNA</u> Middle <u>Lemm</u> Last <u>Lemm</u>                        |                               |   | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>20</u> Year <u>1960</u> |   |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/21/36</u>                                    | 9. AGE (last birthday) <u>24</u>                                    | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>        |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTH PLACE (City and state or country) <u>Bogard, Missouri</u> |  | 12. CITIZEN OF WHAT COUNTRY <u>U. S.</u> |
| 13a. FATHER'S NAME <u>Ernest Monger</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Wilma Cain</u>   |  | 13c. NAME OF HUSBAND OR WIFE <u>Richard Bryant</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. <u>none</u>   |  | 17. INFORMANT Address <u>Mrs. Wilma Monger Savannah, Mo.</u>        |  |  |

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|--|--|--|
| 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) <u>Passive pulmonary hemorrhage</u><br>DUE TO (b) <u>thial pneumonia and</u><br>DUE TO (c) <u>Encephalitis</u> |  | 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |

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|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input 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.) |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____                       | 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 <u>10/24/60</u> to <u>11/20/60</u> and last saw her alive on <u>11/20/60</u><br>Death occurred at <u>2129</u> on the date stated above, and to the best of my knowledge, from the causes stated. |                             |        |       |

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|---|--|---|
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title)             | 22b. ADDRESS <u>2400 Perry City Mo</u>       | 22c. DATE SIGNED <u>11/21/60</u>                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>        | 23b. DATE <u>11/21/60</u>                    | 23c. NAME OF CEMETERY OR CREMATORY <u>Tinley Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Sheil Funeral Home K.C. Mo.</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>11/21/60</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>              |

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF Frank Ellis

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas A. Sheil

Licensed Embalmer No. 4951

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.