

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024477

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 122

AMENDED

FILED AUG 14 1961

1. PLACE OF DEATH
 a. COUNTY Clay
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN North Kansas City, Mo Length of stay in 1b
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION North Kansas City Memorial Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY Clay
 c. CITY OR TOWN Kansas City 16 Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 3505 E. 35th St. N. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Elizabeth Marie Lehman

4. DATE OF DEATH Month Day Year
8 - 4 - 61

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 4-4-78 9. AGE (last birthday) 83 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) Housewife 10b. KIND OF BUSINESS OR INDUSTRY
 11. BIRTHPLACE (City and state or country) COMMERIA, Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME GUSTAV SCHUBHART 13b. MOTHER'S MAIDEN NAME SOPHIA BRANS 14. NAME OF HUSBAND OR WIFE CHARLES E. LEHMAN

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. None 17. INFORMANT Address MRS. ELYAETH HILGREN 3505 35th

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) BANERENE OF IHEUMANOCCUM INTERVAL BETWEEN ONSET AND DEATH 8 hours
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) THROMBOSIS OF MESENTERIC ARTERY 8-12 hours
 DUE TO (c)
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) left HEMIPLEGIA - 1 week ago
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
 a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 August 4, 1961 to August 4, 1961 and last saw her her on August 4, 1961
 Death occurred at 2:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. Comer Bates, M.D. 22b. ADDRESS 730 South MITCHELL KANSAS CITY 19, MISSOURI 22c. DATE SIGNED 8/5/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 8-7-1961 23c. NAME OF CEMETERY OR CREMATORY FOREST HILL Cem. 23d. LOCATION (City, town, or county) (State) KANSAS CITY Mo.

24. FUNERAL DIRECTOR ADDRESS D.W. NEWCOMERS Sons N.K.C.M. 25. DATE RECD. BY LOCAL REG. 8-7-61 26. REGISTRAR'S SIGNATURE Marquette Judgens

DATE AMENDED

INSTEAD OF

ITEM NO. I SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. PEWLE

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 John V. Herrick
Licensed Embalmer No. 4848
P. O. Address K.C. 17/200

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.