

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041137

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4856 STATE FILE NUMBER

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>5 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u> c. CITY OR TOWN <u>Slater</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Box 43</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>E.</u> Last <u>Lightfoot, Sr.</u>		4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>1961</u>	

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1894</u>	9. AGE (last birthday) <u>67</u>	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) <u>Veneer Products</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (City and state or country) <u>New Frankfort, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Edward W. Lightfoot</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Mc Cormick</u>		14. NAME OF HUSBAND OR WIFE <u>--</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>	17. INFORMANT Address <u>Mrs. R. E. Lightfoot, Slater, Mo.</u>
---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolism</u> DUE TO (b) <u>adenocarcinoma of urinary bladder</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>pelvic surgery Sept. 27, 1961</u>	INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>3 yrs.</u>
---	---

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 <u>Sept. 25, 1961</u> to <u>Sept. 30, 1961</u> and last saw her/him alive on <u>Sept. 30, 1961</u> Death occurred at <u>10:45A.</u> _____ on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE <u>F. W. Thompson</u> (Degree or title)	22b. ADDRESS <u>2501 Gillham Rd., K. C. Mo.</u>	22c. DATE SIGNED <u>9-30-61</u>
--	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>9-30-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gilliam</u>	23d. LOCATION (City, town, or county) (State) <u>Gilliam, Mo.</u>
---	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>Haines Funeral Home, Slater, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-30-61</u>	26. REGISTRARS SIGNATURE <u>Ruth Long</u>
---	--	--

DATE AWARDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 _____

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.