SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-044863

STATE FILE NUMBER

AMENDED

Registration District No. 149. Primary Registration District No. 1002 Registrar's No. 6585

FILED JAN 15 1962

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 3 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4001 Warwick Blvd.
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 Holt
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) None
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Walter Middle C. Last Lyman
4. DATE OF DEATH: Month Dec. Day 29 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 3-13-1874
9. AGE (last birthday): 87
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 farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Kentucky
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: George W. Lyman
13b. MOTHER'S MAIDEN NAME: Nannie McClure
14. NAME OF HUSBAND OR WIFE: Lula Lyman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Era Laster, 5325 Lamar Address Mission, Kansas

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral atherosclerosis — 10+ yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Congestive heart failure.
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 a.m. p.m. Month, Day, Year
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 1959 to 12/29/61 and last saw him alive on 12/13/61
Death occurred at 8 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) P. Luckenbill MD
22b. ADDRESS Plattsburg Mo.
22c. DATE SIGNED 12/30/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 12-29-61
23c. NAME OF CEMETERY OR CREMATORY Antioch
23d. LOCATION (City, town, or county) (State) Holt, Mo.

24. FUNERAL DIRECTOR ADDRESS Fry Funeral Home, Kearney, Mo.
25. DATE RECD. BY LOCAL REG. 12-31-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

P. Luckenbill

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 Lindell Jackman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, M

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.