No. 2
-4-13-40
5-17-39
-I X23159

FILLED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17103

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1765

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital () (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Days (Specify whether

In this community 21 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cowley 999

(c) City or town Arkansas City (If outside city or town limits, write "RURAL") 14

(d) Street No. Majestic Hotel (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? ---- 2 years.

3. (a) PRINT FULL NAME Mr. Lyman Sylvester Conkling

3. (b) If veteran, name war No

3. (c) Social Security No. Unknown 512-14-8533

4. Sex Male ()

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Mrs. Lyllie Jane Howard Conkling

6. (c) Age of husband or wife if ------ years

7. Birth date of deceased September (Month) 9 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
70	7	23	hr. min.

9. Birthplace Union County (City, town, or county) / Iowa (State or foreign country)

10. Usual occupation Barber

11. Industry or business Abbey Cline

FATHER
12. Name Elias Van Buskerk Conkling
13. Birthplace Red Oak (City, town, or county) / Iowa (State or foreign country)

MOTHER
14. Maiden name Charlotte Shepherd
15. Birthplace (City, town, or county) 9 Unknown (State or foreign country)

16. (a) Informant Mrs. F. F. Phillips

(b) Address 7516 Olive St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) May 5, 1941 (Date received local registrar) (b) M. M. Crown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd year 1941 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from Apr 10, 1941, to May 2, 1941; that I last saw him alive on May 2, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Cerebral Hemorrhage

Due to Fall and striking head on curb X

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy Mild arteriosclerosis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 1 2 3

(c) Where did injury occur? Arkansas City (City or town) / Kan. (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? () Means of injury

23. Signature Hugh A. Gustrey (M. D. or other) O

Address 302 Northern Bldg. Date signed 5/3/41

(Licensed Embalmer's Statement on Reverse Side)

1 6
2 7 8
1 9

303 Harriman Bldg
12 5; 7-8

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed George M. Collie

Licensed Embalmer No. 3839

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17103

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 1765

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County .....
(b) City or town ..... (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joe J Hoopt
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits write "RURAL")
(d) Street No. Magestic Hotell (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Lyman Sylvester Coulsling
3. (b) If veteran, name war ..... 3. (c) Social Security No. .....
4. Sex Male
5. Color or race Wh
6. (a) Single, widowed, married, divorced Wed
6. (b) Name of husband or wife .....
6. (c) Age of husband, or wife, if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
70			hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) May 1941 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1941 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h... alive on ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia secondary
Due to Cerebral Hemorrhage
Due to Fall + striking head on curb
Other conditions (Include pregnancy within 3 months of death) 186 a
Major findings: Of operations 186 a
Of autopsy 39

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide (specify)~~
(b) Date of occurrence April 6.
(c) Where did injury occur? Ransom city Kans (City or town) (County) (State)
(d) Did injury occur in or about ~~home, on farm, in industrial place, in~~ public place? (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature Hugh A. Gestring (M. D. ~~or other~~)
Address 307 Cust Ransom Date signed .....

S-17103