

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20603

State File No. \_\_\_\_\_  
Registrar's No. 2733

Registration District No. 149 Primary Registration District No. 1002

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. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 weeks  
In this community 7 weeks  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Lena Hyatt  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced unknown  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unk. years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
ADD. 47 hr. min.

9. Birthplace unknown  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOYHER FATHER {  
12. Name unknown 9  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Konantz Funeral Home  
(b) Address Fort Scott, Kans.

17. (a) removal (b) Date thereof 6-19-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fort Scott, Kansas

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 6-19-46 (b) Geraldine Holme  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County 999  
(c) City or town Fort Scott 14  
(If outside city or town limits, write "RURAL")  
(d) Street No. X 0  
(If rural, give location) 2  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18  
year 1946 hour 10:00 minute \_\_\_\_\_ P. \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the \_\_\_\_\_ date and hour stated above.

Immediate cause of death Broncho-pneumonia 2 days  
in Respiratory Atrophy of 6 mo  
Spinal Cord

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Respiratory Paralysis 5 days  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Yes above 82:1

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 \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Stine & McClure (M. D. or other) \_\_\_\_\_  
Address Fort Scott, Mo. Date signed June 19

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

JUL 2 1948

OCT 15 1946  
Dr. P. T. Bohan

SFD 25 1947

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 *J. Clair Shppard*

Licensed Embalmer No. *4579*

P. O. Address *K. C. Mo*

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