

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3324

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Kansas b. COUNTY Lyon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Emporia	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		d. STREET ADDRESS (If rural, give location) 1324 State	

3. NAME OF DECEASED (Type or Print) a. (First) Lyndon b. (Middle) Raymond c. (Last) Street			4. DATE OF DEATH (Month) (Day) (Year) Aug. 2, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 12, 1900	9. AGE (In years last birthday) 50	10. MONTHS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A					

13a. FATHER'S NAME James T. Street	13b. MOTHER'S MAIDEN NAME Bertha Miller	14. NAME OF HUSBAND OR WIFE Garnette L. Street, Emporia, Kansas
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War #1	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mrs. Garnette L. Street, Emporia, Kansas
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 331X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 2, 1950, to Aug 2, 1950, that I last saw the deceased alive on Aug 2, 1950, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE B. J. Burns MD. (Degree or title)	23b. ADDRESS R.C. Gen Hosp #1	23c. DATE SIGNED 8-3-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 8-3-1950	24c. NAME OF CEMETERY OR CREMATORY Emporia Kansas	24d. LOCATION (City, town, or county) (State) Emporia Kansas
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DATE REC'D BY LOCAL REG 8-3-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE G. Fulton	ADDRESS K C Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Ralph G. Fulton

Signed.....

Student Embalmer

Licensed Embalmer No. 3523

P. O. Address KC 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.