

FILED FEB 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5623

|  |   |   |   |  |            |  |   |
|--|---|---|---|--|------------|--|---|
| BIRTH NO. _____  |   | REG. DIST. NO. 21   |   | PRIMARY REG. DIST. NO. 3012  |            | Registrar's No. 8                                      |   |
| 1. PLACE OF DEATH  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |            |  |   |
| a. COUNTY<br>Clay  |   | b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN Excelsior Springs              |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN Lawson  |            | d. STREET ADDRESS (If rural, give location)<br>Box 144 |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>Veterans Administration Hospital  |   | c. LENGTH OF STAY (in this place)<br>unknown  |   |  |            |  |   |
| 3. NAME OF DECEASED (Type or Print)  |   |   | 4. DATE OF DEATH                            |  |            |  |   |
| a. (First)<br>John P. Teegarden  |   | b. (Middle)   | c. (Last)                                   | Date (Month) (Day) (Year)<br>January 17, 1949  |            |  |   |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Married   | 8. DATE OF BIRTH<br>Nov. 14, 1924           | 9. AGE (In years last birthday)<br>24  | 10. MONTHS | 11. DAYS   | 12. HOURS   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Mechanic  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Garage   |   | 11. BIRTHPLACE (State or foreign country)<br>Lenexa, Kansas  |            | 12. CITIZEN OF WHAT COUNTRY?<br>USA                    |   |
| 13a. FATHER'S NAME<br>E. G. Teegarden  |   | 13b. MOTHER'S MAIDEN NAME<br>Zelma J. McClelland  |   | 14. NAME OF HUSBAND OR WIFE<br>Rose Marie Teegarden  |            |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Yes - now in act. service  |   | 16. SOCIAL SECURITY NO.<br>Yes - not rem.   |   | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS<br>Hospital Records, Veterans Administration Hospital, Excelsior Springs, Missouri |            |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.    | MEDICAL CERTIFICATION   |   |   |  |            |  | INTERVAL BETWEEN ONSET AND DEATH  |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Car Accident (Unavoidable)   |   |   |  |            |  |   |
|  | ANTECEDENT CAUSES ON Hiway 69 and 92  |   |   |  |            |  |   |
|  | Morbidity 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<br>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?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT (Specify)<br>Suicide<br>Home - Hiway Accid. V. Highway   |   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., sea)                           |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br>near Excelsior Springs, Clay Missouri   |            |  |   |
| 21d. TIME OF INJURY<br>January 12, 1949<br>approx. 7:30 p. m.  |   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?<br>Highway accident - struck by truck   |            |  |   |
| 22. I hereby certify that I attended the deceased from Jan. 12, 1949, to Jan. 17, 1949, that I last saw the deceased alive on Jan. 17, 1949, and that death occurred at 1:20 p.m., from the causes and on the date stated above. |   |   |   |  |            |  |   |
| 23a. SIGNATURE (Degree or title)<br>D. J. Tate MD Coroner  |   |   | 23b. ADDRESS<br>Excelsior Springs, Missouri |  |            | 23c. DATE SIGNED<br>1/20/49                            |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 24b. DATE<br>1-18-49  | 24c. NAME OF CEMETERY OR CREMATORY<br>Lawson Cemetery   |   | 24d. LOCATION (City, town, or county) (State)<br>Lawson, Mo.   |            |  |   |
| DATE REC'D BY LOCAL REG.<br>1/20/49  |   | REGISTRAR'S SIGNATURE<br>Caroline Hutchings   |   | 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS<br>Hope Funeral Home, Excelsior Springs, Mo.  |            |  |   |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-9-49

MAR 3 1949

REC'D  
FEB 11 1949

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.

Signed \_\_\_\_\_  
Student Embalmer

Signed James A. Moles  
Licensed Embalmer No. 3296

P. O. Address Excelsior Spg 17

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.