

STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1953

State File No. 1185 Registrar's No.

No. 300 10.48

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
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 Kansas City	
c. LENGTH OF STAY (In this place) 26yrs		d. STREET ADDRESS (If rural, give location) 3681 Summit,	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL			

34880

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) W. c. (Last) PILKINGTON			4. DATE OF DEATH (Month) (Day) (Year) February 23 1953		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 18, 1891	9. AGE (In years last birthday) 61	10. MONTHS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (City and State or Foreign Country) Syracuse, Missouri 0	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME John M. Pilkington	13b. MOTHER'S MAIDEN NAME Letitia Duke	14. NAME OF HUSBAND OR WIFE Carola J. Pilkington
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW-1 489-07-6357	17. INFORMANT'S SIGNATURE OR NAME Official Records, VA Hospital, Kansas City, Mo.	ADDRESS Kansas City
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dissecting aneurysm of the Aorta		INTERVAL BETWEEN ONSET AND DEATH 10 seconds
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriolonephrosclerosis with hypertension		15 years
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		451 K

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) m.	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 January 28, 1953, to February 23, 1953, and that death occurred at 12:10 p.m., from the causes and on the date stated above.

23a. SIGNATURE RICHARD C. SCHAEFER, M.D. (Degree or title)	23b. ADDRESS VA HOSPITAL, KANSAS CITY, MO.	23c. DATE SIGNED 2/24/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 26, 1953	24c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 2-26-53	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE W.H. Newcomer	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.
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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
Student Embalmer

Signed

John B. Lewis

Licensed Embalmer No. 4875

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.