

FILED MAY 27 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17901

2361

BIRTH NO.		REG. DIST. NO. 149	PRIMARY REG. DIST. NO. 1002	Registrar's No.
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Wyandotte		
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City	c. LENGTH OF STAY (in this place) 3 Hrs.	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City 8153		
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.		d. STREET ADDRESS (If rural, give location) 282I South 37th.		
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Ray c. (Last) Biles			4. DATE OF DEATH (Month) (Day) (Year) OF May 6 1953	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED Never married	8. DATE OF BIRTH Aug. 22 1943	9. AGE (In years last birthday) 9 if UNDER 1 YEAR Months Days if UNDER 2 YRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ft. Riley, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Arlies Biles		13b. MOTHER'S MAIDEN NAME Iva Marie Windhorst	14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Arlies Biles (Father) KCK	
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) Acute Intestinal Obstruction <i>adhesions</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>operation for ruptured spleen 1 yr. +</i> DUE TO (c) <i>fall in a ditch</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 24 HRS E90-45
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 815		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 5 - 5 19 53 to 5 - 6 19 53, that I last saw the deceased alive on 5 - 6 19 53, and that death occurred at 10:15 P. M., from the causes and on the date stated above.				
23a. SIGNATURE <i>J. W. Young</i> M.D. (Degree or title)		23b. ADDRESS 1401 Southwest Blvd KCK		23c. DATE SIGNED 5-7-53
24a. BURIAL, CREMATION, REMOVAL	24b. DATE May 8 1953	24c. NAME OF CEMETERY OR CREMATORY Glasco Cemetery	24d. LOCATION (City, town, or county) (State) Glasco, Kansas	
DATE REC'D BY LOCAL REG. 5-7-53	REGISTRAR'S SIGNATURE <i>Geraldine Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simmons Funeral Home KCK	

70045-2

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 Max E. Meyer

Licensed Embalmer No. 4555

P. O. Address Kansas City, Mo.

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

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