

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **27223**  
**3597**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>4 years</b>		c. CITY OR TOWN <b>Kansas City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3105 Karnes Blvd.</b>				e. STREET ADDRESS (If rural, give location) <b>3105 Karnes Blvd.</b>					
3. NAME OF DECEASED (Type or Print)			a. (First) <b>James</b>		b. (Middle) <b>C</b>		c. (Last) <b>Dykes</b>		
4. DATE OF DEATH		(Month) <b>July</b>		(Day) <b>22</b>		(Year) <b>1954</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>August 11, 1914</b>			
9. AGE (In years last birthday) <b>39</b>		f. UNDER 1 YEAR Months _____		g. UNDER 1 YEAR Days _____		h. UNDER 24 HRS. Hours _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asphalt Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Bowen Const. Co.</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Emporia, Kansas</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>Samuel Dykes</b>		13b. MOTHER'S MAIDEN NAME <b>Blanche Craig</b>		14. NAME OF HUSBAND OR WIFE <b>-0-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give way or dates of service) <b>Yes W.W. # 2</b>		16. SOCIAL SECURITY NO. <b>710-01-8372</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>John Lanagan-Deputy Coroner</b>					
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) <b>Coronary Thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Atherosclerotic Heart Disease</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Coronary Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH     <b>4200</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <b>Geo. O. Kealhofer MD</b> (Degree or title) <b>Geo O Kealhofer MD Deputy Coroner</b>				23b. ADDRESS <b>405 S. Burdway St. Cass</b>		23c. DATE SIGNED <b>7-22-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>7/24/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Neosho Rapids, Kansas</b>			
DATE REC'D BY LOCAL REG. <b>7-23-54</b>		REGISTRAR'S SIGNATURE <b>Heraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Quirk &amp; Tobin, 20 W. Linwood, K.C. Mo.</b>					

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

SEP 20 1954

AUG 19 1954

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, ~~only~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Forest D. Coldsnow*.....

Licensed Embalmer No. *4714*..

P. O. Address *K. C. M.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.