

FILED JAN 3 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40936  
5691

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> <u>6007</u>	
b. CITY OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>North Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>76 days</u>		STREET ADDRESS (If rural, give location) <u>2109 E. 26th Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Wesley</u> c. (Last) <u>GEER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>December 12, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u>	8. DATE OF BIRTH <u>5-26-89</u>	9. AGE (In years) (Last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>East Leavenworth, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Thomas R. Geer</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Moppin</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED Belle Geer</u>
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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) <u>Yes WW1</u>	16. SOCIAL SECURITY NO. <u>511034647</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Official VA Hospital Records</u>	ADDRESS _____
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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 <u>2 days</u>  <u>2 days</u> <u>10 yrs</u>  <u>4201</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Agranulocytopenia</u>		
	ANTECEDENT CAUSES <u>Due to Quinidine toxicity</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>left ventricular and septal infarct, old</u>		
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			

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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 9-27, 19 54, to 12-12, 19 54 and I had had the deceased alive by 11/11/54 and that death occurred at 7:15A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dorthea Weybright</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>Veterans Administration Hospital</u>	23c. DATE SIGNED. <u>12-12-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>DEC 12, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>PLATTE CITY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>PLATTE CITY MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>12-12-54</u>	REGISTRAR'S SIGNATURE <u>Neve Minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. DAVIS UNDERTAKING CO.</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

~~STATEMENT BY LICENSED EMBALMER~~  
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.....  
Signature of Student Embalmer

Signed *Chas E J Menden*

Licensed Embalmer No. *2015*

P. O. Address *Greenworth*

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.