

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33092
State File No. _____
4134
Registrar's No. _____

FILED OCT 19 1955

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

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. LENGTH OF STAY (in this place) 44 years	c. CITY OR TOWN KANSAS CITY
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		5. STREET ADDRESS (If rural, give location) 3408 MERSINGTON	

3. NAME OF DECEASED (Type or Print)	a. (First) WILLIAM	b. (Middle) RALPH	c. (Last) BIRD	4. DATE OF DEATH (Month) (Day) (Year) September 22, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 4, 1911	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months	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) Mechanical high loader	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Fairfield, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Lemuel Bird	13b. MOTHER'S MAIDEN NAME Oda Crabtree	14. NAME OF HUSBAND OR WIFE Mabel
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, N, or unknown) Yes (If yes, give year or dates of service) World War II	16. SOCIAL SECURITY NO. 536-05-6785	17. INFORMANT'S SIGNATURE OR NAME Official VA Hospital Records, K. C. Mo.	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, asphyxia, 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) Myocardial infarction		DUE TO (b) Coronary atherosclerosis		3 1/2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Unknown		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		4 1/2

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) VA	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 Sept. 16, 1955, to Sept. 22, 1955, and that death occurred at 5:20 Pm., from the causes and on the date stated above.

23a. SIGNATURE Glen G. Halliday M.D.	23b. ADDRESS VA Hospital, Kansas City, Mo.	23c. DATE SIGNED 9-22-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-23-55	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) Fairfield, Mo.
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DATE REC'D BY LOCAL REG. 9-23-55	REGISTRAR'S SIGNATURE Neva Minchell	25. FUNERAL DIRECTOR'S SIGNATURE Mellody-McBilley-Eyler KC Mo.	ADDRESS
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WRITE PLAINLY - GIBBO UNFOLDING BLACK INK - MAKE A PERMANENT RECORD

APR 29 1952

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by, Student Embalmer No.....

..working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Melvin Partee*.....

Licensed Embalmer No.....

P. O. Address *Ke...*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.