

Health, Welfare
Public Service

300
1-56

Use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30944

STATE FILE NUMBER
4172

FILED OCT 3 1956

Registration District No. 149 Primary Registration District 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 MISSOURI b. COUNTY JACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN INDEPENDENCE,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL			Length of stay in lb 1 year 20 days		d. STREET ADDRESS (If outside, give location) 326 WEST SOUTH AVE		
3. NAME OF DECEASED (Type or print) First MIDDLE Last LEROY (NMI) SEARCY, Sr.				4. DATE OF DEATH Month Day Year September 21, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 22, 1924	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Ice Company		11. BIRTHPLACE (City and state or country) Gillette, Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dewey Earl Searcy				14. MOTHER'S MAIDEN NAME ROTH Letha Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 3/25/48-3/24/52		16. SOCIAL SECURITY NO. 493-22-5333		17. INFORMANT Address VA Hospital Official Records, K. C. Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Embryonal carcinoma, left testes; metastases						14 months	
DUE TO (c)						198X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Aug. 31, 1955 to Sept. 21, 1956 Death occurred at 6:58 AM m on the date stated above; and to the best of my knowledge, from the causes stated.							
21a. SIGNATURE (Degree or title) J. A. TURNER, M.D.				21b. ADDRESS VA Hospital, Kansas City, Mo.		21c. DATE SIGNED 9/21/56	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE SEPT. 24 1956		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) INDEPENDENCE MISSOURI	
24. FUNERAL DIRECTOR ADDRESS DW NEWCOMER'S SONS 1331 BRUSH CREEK KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. 9-24-56		26. REGISTRAR'S SIGNATURE Iva Marshall		

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul B. Williams*

Licensed Embalmer No. *500*

P. O. Address *K.C. Mo.*

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