

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37344

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 4915

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>Woods</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION</b>		Length of stay in 1b <b>1 week</b>	d. STREET ADDRESS <b>1021 S. 56TH</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM JAMES CROCKETT</b>			4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 22, 1918</b>	9. AGE (In years of birthday) <b>37 3/4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Terminal Elevator</b>	11. BIRTHPLACE (City and state or country) <b>Chanute, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jay Crockett</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Tempale</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>510 05 3413</b>	17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding esophageal varices</b>					INTERVAL BETWEEN ONSET AND DEATH <b>58 1/2</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Post-necrotic cirrhosis</b>			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input 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 WORK <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. Attended the deceased from <b>November 5, 1956</b> to <b>November 12, 1956</b> Death occurred at <b>11:10 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert E. Qualheim</b> (Degree or title) <b>M. D.</b>			22b. ADDRESS <b>VAH Kansas City, Missouri</b>		22c. DATE SIGNED <b>11/13/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Nov. 16, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>VETERAN'S CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WADSWORTH KANSAS</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		ADDRESS <b>KANSAS CITY, KANS.</b>		25. DATE RECD. BY LOCAL REG. <b>11-14-56</b>	26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**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.....  
*James T. Deuss*

Licensed Embalmer No. *4443*

P. O. Address *75 Cass St*

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.