

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5048

FILED FEB 18 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 422

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| 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>JACKSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 43. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V.A. Hospital</u> | | Length of stay in lb <u>3 and 1/2 month</u> | d. STREET ADDRESS (If outside, give location) <u>2825 Harrison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>R.</u> Last <u>TEATER</u> | | | 4. DATE OF DEATH Month <u>1st</u> Day <u>26th</u> Year <u>1957</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-29-95</u> | 9. AGE (In years last birthday) <u>61 yrs</u> 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) <u>Hotel Manager Trainee</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | 11. BIRTHPLACE (City and state or country) <u>Blairs Town, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>CALVIN TEATER</u> | | | 14. MOTHER'S MAIDEN NAME <u>ADA STARK</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 3-4-18 to 1-4-19</u> | | 16. SOCIAL SECURITY NO. <u>499-10-0559</u> | 17. INFORMANT Address <u>V.A. Hospital Records, K.C., Mo.</u> | | |

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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade -- hemopericardium</u> | | | | INTERVAL BETWEEN ONSET AND DEATH Inst. <u>451X</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <u>Dissecting aneurysm of the aorta</u> | | |
| | | DUE TO (c) <u>Medial necrosis of the aorta - arteriosclerosis</u> | | |
| 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 checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 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 | | STATE |

21. Attended the deceased from January 11, 1957 to January 26, 1957 and performed the death occurred at 5:55 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Howard P. Fink M.D.</u> (Degree or title) | 22b. ADDRESS <u>V.A. Hospital, Kansas City, Mo</u> | 22c. DATE SIGNED <u>1-27-57</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>JAN. 25 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>SEASIDE MISSOURI</u> |
| 24. FUNERAL DIRECTOR <u>DW. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY MO</u> | 25. DATE RECD. BY LOCAL REG. <u>1-28-57</u> | 26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u> | |

(Licensed Embalmer's Statement on Reverse Side)

Death, self-reports, or other information must be stated. Coroner must certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be stated. An unusual or unusual disease in Part I must be casually related. Coroner must certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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 *Chester K. Broe*

Licensed Embalmer No. *4*

P. O. Address *KE*

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.