

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in their reports. NO symptoms with use listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31826  
STATE FILE NUMBER  
3923  
Registrar's No.

FILED SEP 19 1957

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>		Length of stay in lb <b>12 years</b>	d. STREET ADDRESS <b>501 MAPLE AVENUE</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>(NMI)</b> Last <b>DUSIE</b>			4. DATE OF DEATH <b>August 20, 1957</b> Month Day Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1906</b>	9. AGE (In years last birthday) <b>50</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Room employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINER</b>		11. BIRTHPLACE (City and state or country) <b>Twin Rocks, Pa.</b>	
13. FATHER'S NAME <b>James Dusie</b>			14. MOTHER'S MAIDEN NAME <b>Magga Penta</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>NONE</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>Erosion of pulmonary artery</b> DUE TO (b) <b>Lung abscess</b> DUE TO (c) <b>unknown etiology</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE CONDITION GIVEN IN PART I (a) <b>CA prostate, diabetes mellitus, arteriosclerosis obliterans, Atherosclerosis, generalized</b>					INTERVAL BETWEEN ONSET AND DEATH <b>521 XH</b>
20b. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20d. TIME OF INJURY Hour . . . . . a. m. p. m.		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			
20f. CITY, TOWN, OR LOCATION		CITY, TOWN, OR LOCATION		STATE	
21. I attended the deceased from <b>January 15, 1957</b> to <b>August 20, 1957</b> Death occurred at <b>6:10 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>C. E. Andrews</b> (Degree or title)			22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>8-20-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>AUG 21-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>DU QUOIN ILLINOIS</b>
24. FUNERAL DIRECTOR <b>D.W. NEINCOMER'S SONS</b>		ADDRESS <b>1331 BRUSH CREEK KANSAS CITY MO.</b>		25. DATE RECD. BY LOCAL REG. <b>8-21-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



THIS BODY

WAS

ORDER

DATE

DATE OF DEATH

AGE

SEX

RACE

PLACE OF BIRTH

EDUCATION

RELIGION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

STATE OF TEXAS, COUNTY OF DALLAS, CITY OF DALLAS

DATE

TIME

BY

**STATEMENT BY LICENSED EMBALMER**

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

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

working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Edward M. Se...*  
.....

Licensed Embalmer No. *40*

P. O. Address *V.S.C. 110*

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.